The Modern Hospital

MAY 1961

Food Service Moves Along at Beckley Memorial Hospital (P.120)

THIS IS Aspen

a new B.F.Goodrich Koroseal vinyl wall covering

Aspen, latest fabric-backed Koroseal vinyl wall covering by B.F.Goodrich, comes in 23 wall-toned colors and features all of the maintenance-free qualities of other Koroseal coverings. It is scuff, scratch and stain resistant, flame-proofed and washable with soap and water.

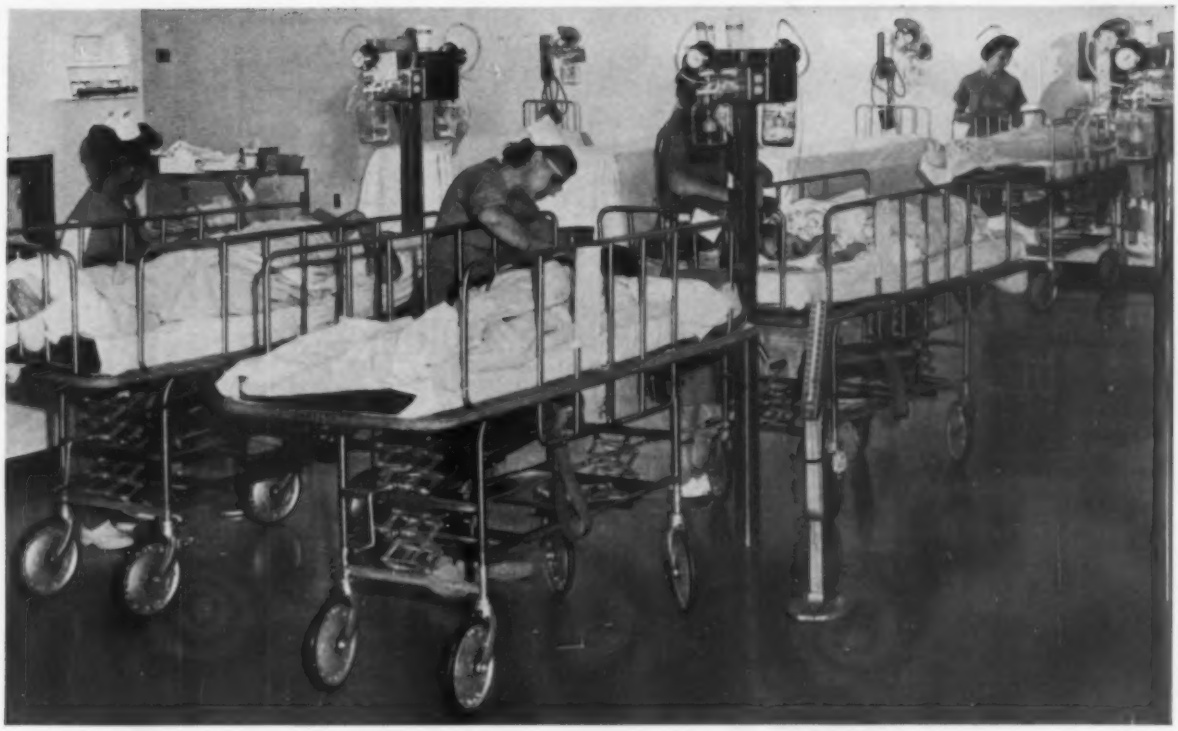
The durability of Koroseal drastically reduces one of the most costly building maintenance items, periodic wall repainting. Expensive labor, paint, and even complete shutdown of income producing space cut sharply into building operation profits. And painted walls usually begin to look shabby long before repainting takes place. Koroseal covered walls keep their rich, clean appearance for years. For samples of new Aspen or other Koroseal patterns, write Dept. MH-5, *B.F.Goodrich Industrial Products Company, Marietta, Ohio.*

Koroseal wall coverings blend beautifully with other functional low-maintenance materials such as ceramic tile, marble, wood, stone and brick.

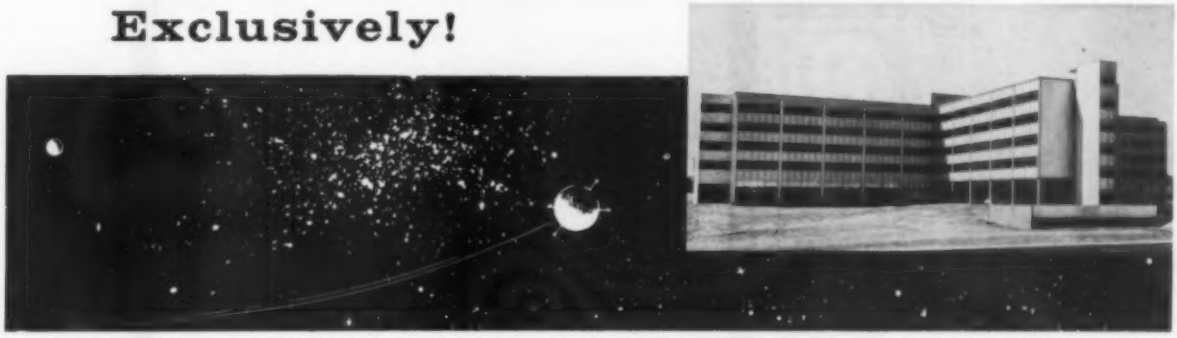
B.F.Goodrich

Koroseal®

VINYL WALL COVERING



NEW "SPACE AGE" HOSPITAL uses HAUSTED Wheel Stretchers Exclusively!



New Memorial Hospital of Long Beach, Calif., called a "Space Age" hospital because of its extremely modern facilities, including a heliport, electronic message system, electronic transcribing system, etc., chose Hausted Wheel Stretchers for Recovery, Emergency, X-Ray and all their patient handling.

This ultra-modern hospital's preference for Hausted equipment bears out the Hausted slogan, "Tomorrow's Equipment Today."

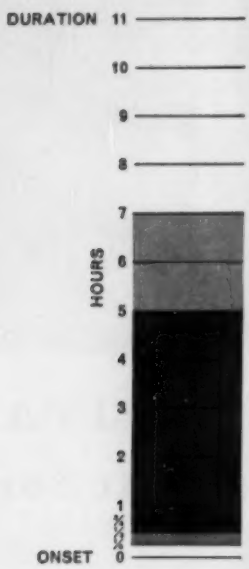
Ask your Simmons Contract salesman or Hausted representative for a live demonstration in your hospital.

SIMMONS COMPANY
HAUSTED DIVISION

MEDINA, OHIO

For additional information, use postcard facing back cover.

for rapid sedation of short duration



SECONAL® SODIUM

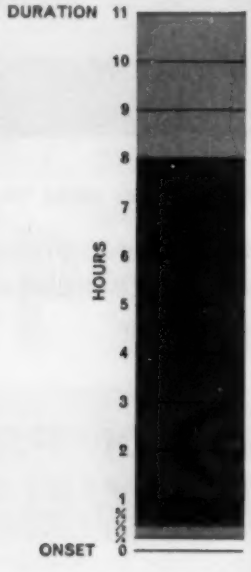
(secobarbital sodium, Lilly)

when the patient must sleep

Probably the most frequent type of insomnia is sleeplessness caused not by physical discomfort but by mental unrest. Seconal Sodium is particularly useful in such cases. Sleep, once started, usually continues throughout the night. The patient awakens feeling refreshed and free from aftereffects.

Seconal Sodium, in adequate dosage, usually brings sleep within fifteen to twenty minutes. Rarely is more than 0.1 Gm. (1 1/2 grains) needed, and often 0.05 Gm. (3/4 grain) is sufficient.

for rapid sedation with prolonged effect



TUINAL®

(amobarbital sodium and secobarbital sodium, Lilly)

when sleep must be sustained

Occasionally, when the insomnia is of a more complex nature, the patient has difficulty in falling asleep and may also awaken in the early hours. This type of insomnia usually responds to Tuinal—a combination of rapid-acting Seconal Sodium and moderately long-acting Amytal® Sodium.

Tuinal may be given in doses of 0.1 Gm. (1 1/2 grains) for less severe cases. For more profound hypnosis of longer duration, the 0.2-Gm. (3-grain) Pulvule® may be used.

Amytal® Sodium (amobarbital sodium, Lilly)

122907

The Modern Hospital

MAY 1961 VOLUME 96, NO. 5

Continued on next page ▸

The Modern Hospital

MEDICINE AND PHARMACY

FOOD SERVICE

MAINTENANCE AND OPERATION

HOUSEKEEPING

REGULAR FEATURES

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READER OPINION

Congratulations and Answer to Rebuttal

Sirs:

Congratulations to Messrs. Sigmond and London on their rebuttal to my challenge of their initial article.* I will be watching the remainder of their series with inspired interest. I must say that they came back at me with a double-barreled shotgun, and with blood in their eyes. Thus, they have stimulated more discussion and consideration of these studies than would have taken place had I not issued the call.

I challenged the sincerity, not as a personal reflection on their integrity, but as a warning that the statistics might be misleading when in the possession of others who may not have the wisdom and judgment to make use of the knowledge presented.

I have personal knowledge of several hospitals throughout Ohio and West Virginia that often have beds in their corridors for a week or more to meet peak demands. The annual occupancy rate of these hospitals is listed at 85 to 90 per cent. However, there are days, even weeks, when the actual occupancy rate is as much as 105 or 110 per cent. During these periods no one knows the number of patients refused admission. This may not be a problem in the Pittsburgh area where patients can be accommodated in other hospitals. It is a serious problem in many areas.

It is hoped that the Sigmond and London studies will not lose sight of the "National Goals for Health Facility Construction" as presented in the October 1959 issue of The Modern Hospital.

J. A. Millard, P.E.
Hospital Consulting Engineer
Lima, Ohio

*London, Morris, and Sigmond, Robert M.: Are We Building Too Many Hospital Beds? Mod. Hosp. 96:59 (January) 1961.

Where Are Those Credits?

Sirs:

As a subscriber to your magazine, I'm doubly annoyed to find the Sun Valley Hospital designed by this office featured in the February issue without architectural credit.

Possibly you did not have the name of the architect from your source of information for your article. However, I do not understand your printing the article without obtaining the architect's name. . . .

Nat J. Adams
Nat J. Adams and Associates
Architects
Boise, Idaho

Editor's Note: *We're sorry sorry.*

Noise Annoys Him, Too

Sirs:

As a former patient and a taxpayer, I was delighted to see that the Public Health Service is doing something about noisy hospitals ("How To Keep Hospitals Quiet," April).

The last hospital I was in sounded like the charge of the light brigade every time the lights were turned low. Certainly some noise is excusable, but there is no reason that doors must slam in this age of mechanical improvements.

(name withheld by request)

ROVING REPORTER

This Hospital Put Fair Play To Work

Although the "equal opportunity" program at Middlesex General Hospital, New Brunswick, N.J., was consciously planned, its success is due chiefly to the unheralded, routine way it has been accepted and carried out by employes.

The program has been under continuous development and operation since 1954. At that time it was decided that all patients were to be treated impartially, with regard given only to their medical, psychological and other needs. Employes, or potential employes, were also to be judged only on the basis of their attitudes, abilities, experience and conscientiousness — that is, on their value to the hospital, the public health cause, and the welfare of the patient.

We realized that the program could not be contrived. Success could not be achieved by surveys, graph plotting, apportionment or synthetic devices, such as memorandums. It was evident that the distribution of races, nationalities and creeds within the bounds of the hospital would inevitably evolve in the same natural way in which the composition of a community or state is evolved, without any conscious effort by the hospital to do so.

Middlesex General Hospital has about 400 employes, 44 per cent of whom come from among the nonwhite groups. The largest group is employed in the nursing and plant operation departments. Approximately half of nursing department employes, including R.N.'s, nurse's aides and assistants, orderlies and ward clerks, are from other than the Caucasian group, and are predominantly Negro. Nearly this same ratio holds true in plant operations, housekeeping, laundry, maintenance, dietary and security departments.

Of greater significance was the discovery that a natural distribution of peoples occurs in all of the hospital's employment categories. We found a diversity of backgrounds in positions of skill, education and prestige, as well as in the manual jobs.

The program is essentially one of equal opportunity, not just racial integration. Integration is merely permitting porters and nurses to eat in the same dining room. Equal opportunity for employes is giving each the chance to elevate his job stature through his own efforts.

Local public attention came to our equal opportunity program recently when the New Brunswick area Urban League presented Middlesex General Hospital an award for "outstanding achievement in human relations."

The award really only served to dramatize a program which has been under continuous development and operation for more than seven years. The hospital is, of course, extremely gratified at the commendation it has received. But to continue successfully the human relations program must be a matter of course. Middlesex hopes that the institution will return to business-as-usual, and "equal opportunity" will be a practice and not just a "program."—JOHN H. BEDDOW, *director, Middlesex General Hospital, New Brunswick, N.J.*

For additional information, use postcard facing back cover.

POSITIVE DECONTAMINATION

• BEDPANS • URINALS

American cyclo-flush

Automatic, positive decontamination with the American Cyclo-flush protects patients and hospital personnel by limiting the carrying of communicable diseases via bedpans and urinals. The electromatic Cyclo-flush thoroughly washes all inside and outside surfaces of pan and chamber with a 25-second cycle of air-entrained cold water — then instantly, steam at 212° F. saturates interior of chamber for 30 seconds . . . killing communicable disease organisms. End result is a sparkling clean utensil ready for use in *any* department or ward.

Amsco Cyclo-flush is finished in vitreous enamel, assuring protection against residual stain and corrosion. Flushing of chamber and pan is complete and thorough.

Time-saving feature of the Amsco Cyclo-flush is important additional benefit. Upon insertion of pan into Cyclo-flush chamber, nurse is free to leave unit and do other work . . . while the utensil is being cleaned AUTOMATICALLY.

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Dolls Do Dual Public Relations Job

A project designed to improve the hospital's public relations turned out to be an important morale building device for employes at Tallahatchie General Hospital, Charleston, Miss.

As a public relations idea the hospital chose *health careers* as its theme for its annual display at the county fair, and asked employes to help it tell the hospital story with dolls representing various hospital careers. To build up interest a hospitalwide contest was held for the best dressed doll that most aptly portrayed the careers in hospitals.

Long before the county fair, the public heard about the contest and became interested because all work on the projects was done at home on the employes' own time. For many employes the dolls became family projects.

The contest was a success; in fact, it evoked much more enthusiasm than had been expected, and the dolls representing the various careers turned out to be full-size hospital departments — on a miniature scale.

Where the contest committee expected a doll representing a surgical nurse, they were presented with an entire surgical suite including operating room table, anesthetic machine, I.V. stand with bottle and miniature needle, mask, nurses, doctors and a patient.

Instead of just one registered nurse, an entire patient room setup was received. This included a hospital bed, bedside table with a fruit arrangement on it, water pitcher, an orderly, and a registered nurse standing by a patient in traction, complete with elastic bandage and miniature pulleys and weights made from cork stoppers.

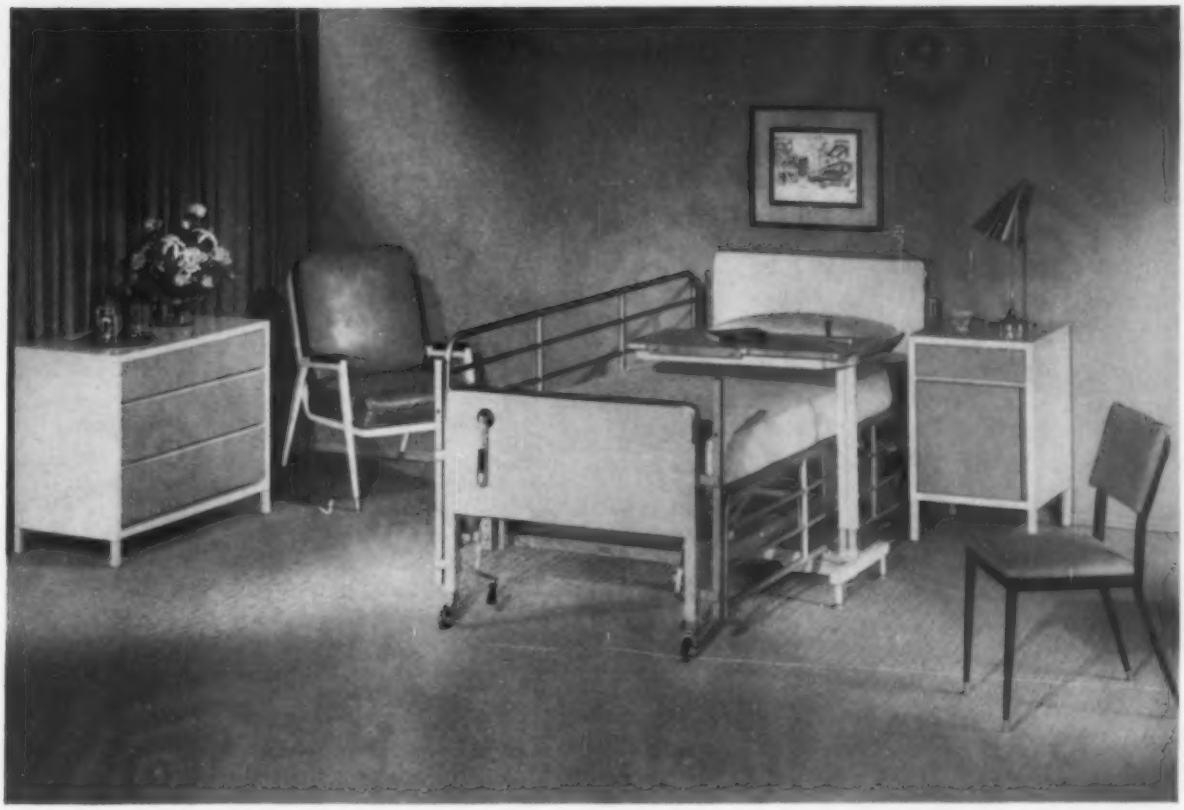
All departments were represented in the contest. Each department grouping was mounted on a platform and attached to a large board holding a miniature scale model of the entire hospital (see picture). This model was entered in the county fair. The community now has a better idea of the many departments, professions, jobs and equipment in the hospital; and the employes have a renewed pride in their hospital.

Tallahatchie General has been invited to display the project at the public schools in Charleston during their career weeks. The Mississippi Hospital Association invited the hospital to display it at the annual convention. And merchants have offered store windows to display the various parts for National Hospital Week, keeping this one public relations idea before the public longer than expected. — WARNER N. KASS, *administrator, Tallahatchie General Hospital, Charleston, Miss.*

Exhibit Travels to Association Meeting

Viewing the Tallahatchie General Hospital's health careers display, shown at the Mississippi Hospital Association's annual meeting, are, left to right: Charles W. Flynn, executive director of M.H.A., Reed B. Hogan, president, Mississippi Hospital Association, and Warner Kass, administrator, Tallahatchie General.

SPRING AIR. ...Enters the Hospital Furnishing Field



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Public Relations

Changing Hospital Horizons Require New Guideposts in Public Relations

By Gordon Davis

WE ARE rudderless in a storm-torn sea. We are without compass and the stars are obscured. We cannot tell whence we have come or whither we go.

Gordon Davis

In plainer English, it is of greatest importance to realize that effective public relations cannot be achieved without detailed policy guidance. If you have ever been in doubt as to your proper conduct in a public relations dilemma — costs criticism, unionization, controversial legislation, damaging accusations — you know how welcome a few guideposts can be.

Guideposts are needed even in pleasant weather, for the sea of public relations is gigantic and one can sail for weeks beyond sight of land.

Let us call these guideposts principles, and let us attempt in this and succeeding columns to establish some of the principles that should direct us in dealing with leading hospital public relations problems.

Presumably we operate within the framework of certain principles at present. Hospitals are dedicated, for example, to the principle that the patient comes first and that nothing must be allowed to interfere with the provision of the best possible patient care.

But this is not nearly specific enough. If we are to know how the same basic principle should govern our attitudes toward rising costs, relationships with Blue Cross, or employe wage levels, we must fully develop the appropriate corollaries.

The job of adjusting the rules to meet changed conditions is never-ending.

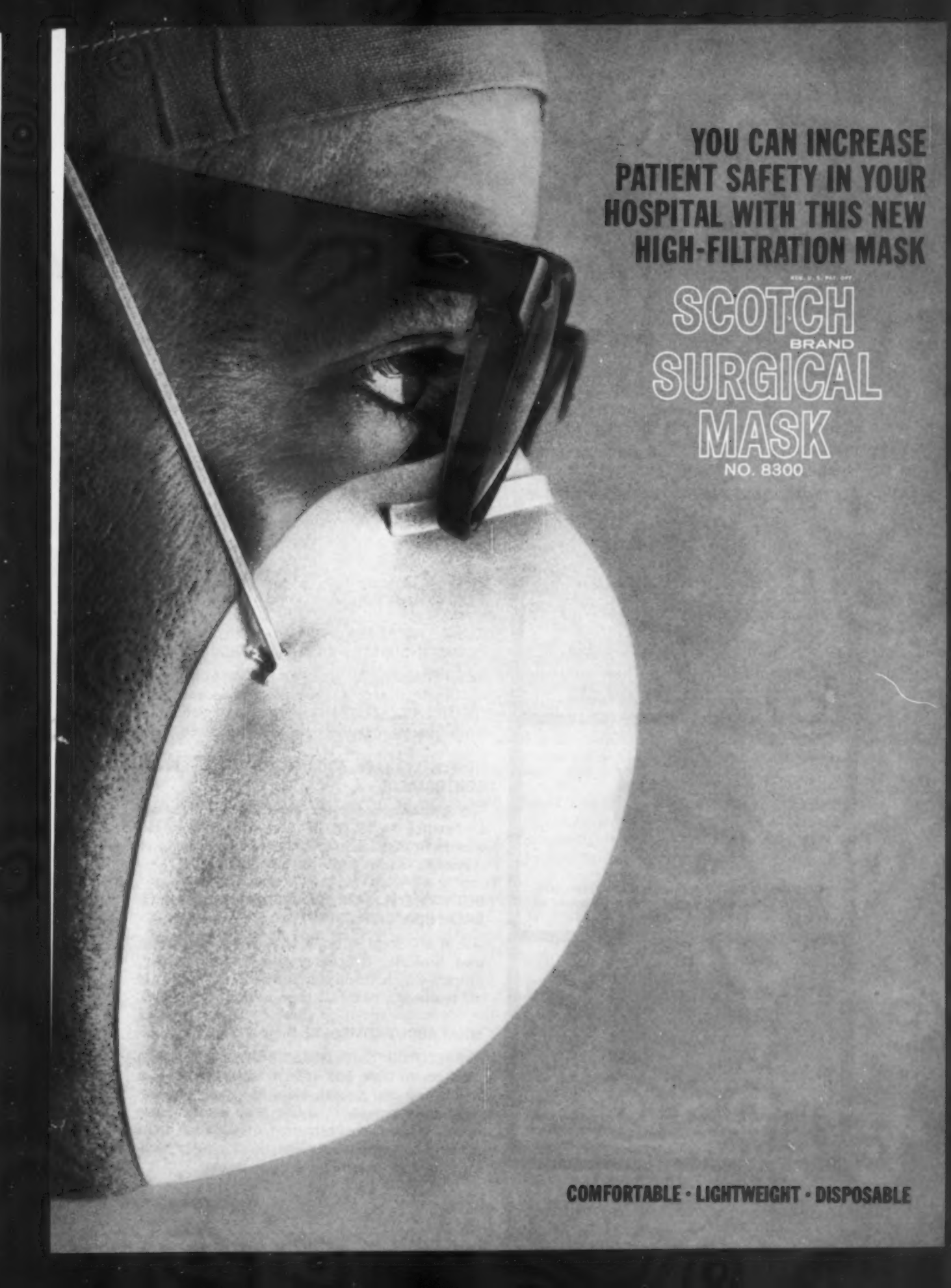
Today, for instance, few hospitals justly can lay claim to the traditional status of charitable institutions, although they stilll perform some of the highest expressions of human compassion and charity. An institution which has just presented a $300 bill for an eight-day stay will never convince a patient that it is charitable.

Thus a public relations endeavor conducted like that of a charity stimulates disbelief and even antagonism. Updating of the charitable concept as it affects hospitals is much in order, and indeed is essential if it is not to be lost on the shoals of public skepticism.

Can we identify the areas in which the hospital is still a charity? Is it possible to state the principles governing today's hospital economy? Can we set forth the principles of community, employe, government and professional relationships that should guide us and dictate our conduct?

Of course we can. We can because we must, if any part of the voluntary system is to be left standing.

So we will begin next month to retrace our steps in search of the principles that brought us where we are, in quest of the best adaptation to the circmustances of today's America. If nothing more, we should learn from the act of trying. ■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HERE ARE THE FACTS ON THE NEW SCOTCH® BRAND SURGICAL MASK

REG. U.S. PAT. OFF.

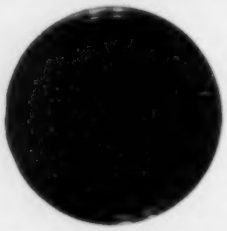
HOW DOES THE "SCOTCH" BRAND SURGICAL MASK COMPARE IN FILTERING EFFICIENCY WITH GAUZE MASKS?

In hundreds of controlled comparative tests (utilizing both in-use and mechanical sampling methods ... both new and used masks ... both brief and sustained testing periods) the "SCOTCH" Surgical Mask averaged up to 35 times more effective than gauze in filtering out airborne bacteria.

TYPICAL TEST RESULT: (masked subjects, 2 minute test period)

1 **"SCOTCH" SURGICAL MASK.** Test shows development of average of only 3 colonies. "SCOTCH" Surgical Mask removed average of 99.4% of airborne organisms.

2 **STANDARD GAUZE MASK.** Average of 105 colonies developed. Test series indicated gauze mask removed average of only 76.4% of organisms.



3 **NO MASK.** As a control, series of plates were exposed for two minutes to unmasked subjects. Average growth was 445 colonies.

WHY IS THE DESIGN AND CONSTRUCTION OF THE "SCOTCH" SURGICAL MASK SO EFFICIENT?

The "SCOTCH" Surgical Mask is molded of a new stabilized-porosity synthetic fabric with an unusually high filtration capacity. Unlike soft, woven fabrics such as gauze, its built-in porosity is permanent. There is little or no variation from mask to mask and no radical loss of efficiency due to compression, matting, or wetting during use.

HOW DOES THE CONTOURED SHAPE OF THE MASK INCREASE ITS FILTERING EFFICIENCY?

Because it is held away from the mouth and nostrils, virtually the entire inner surface of the "SCOTCH" Surgical Mask acts as a filter. Exhaled moisture droplets are not propelled through a small area, but are dissipated at low velocity within the mask.

MUST THE "SCOTCH" SURGICAL MASK BE CHANGED DURING PROLONGED PROCEDURES?

Rarely. Whereas gauze masks rapidly lose efficiency due to wetting and must be changed frequently, the "SCOTCH" Surgical Mask shows little or no drop-off in filtering effectiveness in extended use.

HOW IS LEAKAGE AROUND THE MASK EDGES CONTROLLED?

The adjustable nose piece, contour shape and elastic band of the "SCOTCH" Surgical Mask provide a close fit that minimizes air leakage. Fogging of glasses is almost totally eliminated.

DOES THE MASK'S HIGH FILTRATION MAKE BREATHING DIFFICULT?

Not at all. Because of its large effective filtering area, breathing is actually easy. There is no significant CO_2 build-up within the mask. Speech is not muffled.

WHAT ABOUT COMFORT?

The "SCOTCH" Surgical Mask has been called "the most comfortable yet." It is lightweight (9 masks weigh only one ounce). Measured skin temperatures have proved 1° cooler than inside gauze masks. Vision is not obstructed. Elastic band holds mask in correct position without slipping or binding. There are no strings to tie or adjust.

Enthusiastically accepted. The "SCOTCH" Surgical Mask shown in use in a leading midwestern hospital—one of the many institutions that have already standardized on this high-filtration disposable mask.

IS THE "SCOTCH" SURGICAL MASK EXPENSIVE TO USE?

No. An independent six-month cost study at a leading hospital showed virtually identical over-all costs whether the "SCOTCH" Surgical Mask or gauze masks were used. "SCOTCH" Surgical Masks cost approximately 9 cents each at quantity prices . . . eliminate all inspection, laundry and re-sterilization costs.

CAN THE MASK BE AUTOCLAVED?

Yes. While this mask is designed and priced to be fully disposable, it may be steam autoclaved with no loss of filtering efficiency.

HOW CAN YOU TRY THE "SCOTCH" SURGICAL MASK IN YOUR HOSPITAL?

Your surgical supply dealer can fill your trial order promptly—box of 50 masks, only $6.00; case of 10 boxes, $54.00†. Or, for free samples and additional literature, contact your 3M Sales Representative or write to 3M Company, Dept. NAN-51, 900 Bush Avenue, St. Paul 6, Minnesota.

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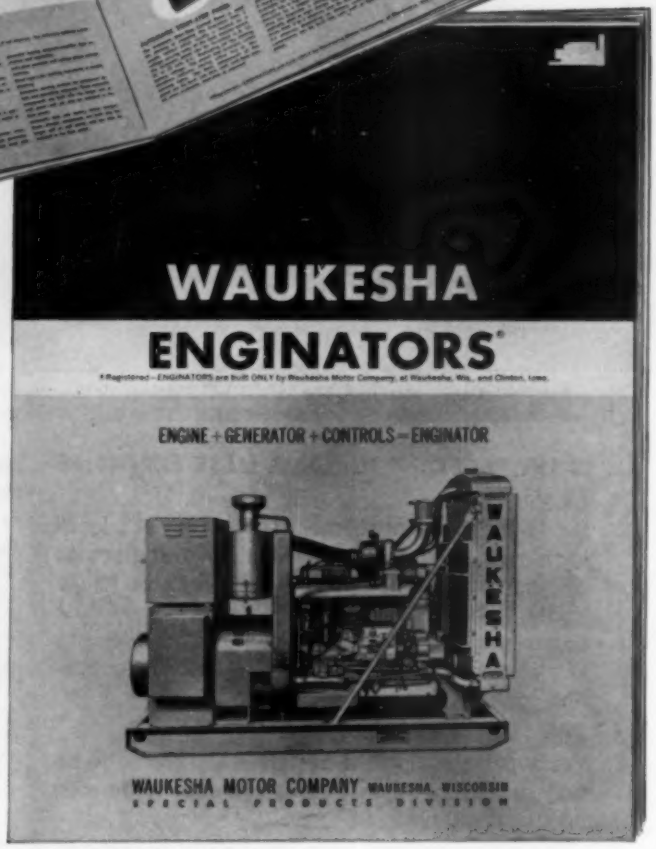

511

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The Huntington Patient-Safety Program

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- More than 100 Huntington products that will effectively help combat the spread of infection from the admitting office to the O.R. suite, the nursery, everywhere in the hospital.
- An intelligent Huntington representative to help you plan the program to meet your specific needs. Individual hospital aseptic problems differ because of variations in layout, in function and in use. The job of the Man behind the Huntington Drum is to select the right Huntington product or products for your hospital. He will show you how to efficiently and effectively use these products to destroy bacteria on all surfaces.
- An experienced Huntington representative whose advice and suggestions will greatly assist you while building and maintaining your Patient-Safety Program. His experience in the hospital aseptic control field averages 19 years.
- A company that completely backs up its men and products with research laboratories that place quality above all else. For over 41 years, these laboratories have been enforcing rigid control over the Huntington manufacturing processes.

Call or write today. Get more details on the Huntington Patient-Safety Program.

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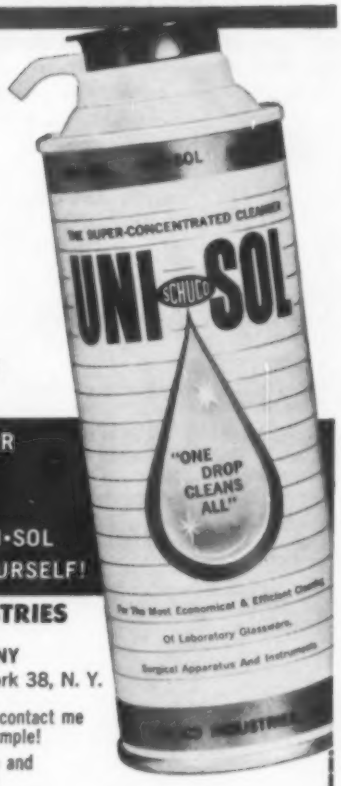

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UNI·SOL IS INSTANTLY SOLUBLE... FREE RINSING... NO STIRRING REQUIRED... UNEXCELLED CLEANING ACTION! Instantly dissolves in any kind of hot or cold water... will not aggregate in solution... leaves no deposits or scum... penetrates into irregular and inaccessible surfaces... equipment dries clean, lint-free and streakless!

UNI·SOL REMAINS STABLE! Cannot dry or cake... guarantees full detergent action every time!

ASK YOUR DEALER FOR A FREE PROFESSIONAL SAMPLE- TRY UNI·SOL ... CONVINCE YOURSELF!

SCHUCO INDUSTRIES
A Division of
SCHUELER & COMPANY
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☐ Please have salesman contact me to arrange for FREE sample!
☐ Please send Literature and Technical Information!

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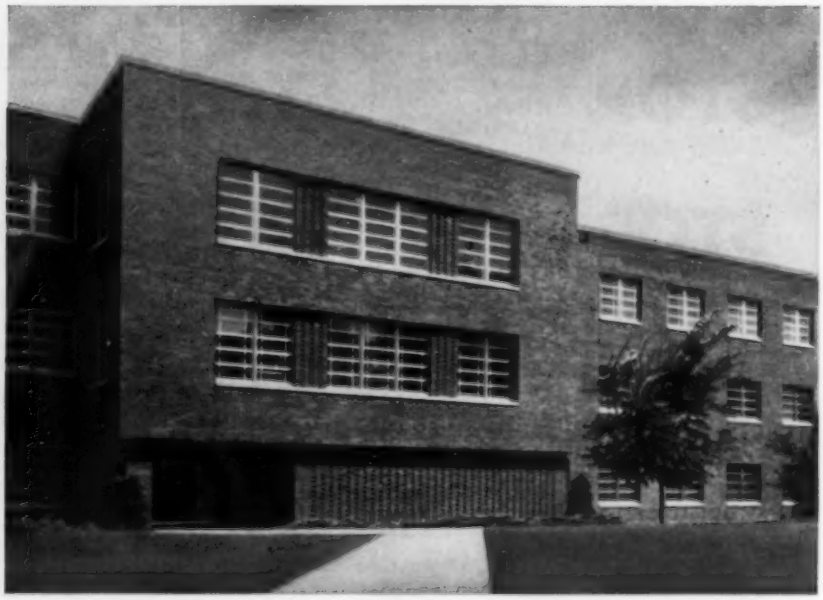
How *Imaginative Engineering* Uses Pneumatic Temperature Control To Guarantee Year 'Round Patient Comfort

Scott & Kinney, Kansas City consulting engineers, took a new look at an old problem and designed a *different* heating and air conditioning system for the University of Kansas Psychiatry Building. Their unusual method features two separate fan systems and a unique automatic damper application that eliminates the noise and distribution problems usually encountered with ordinary single-fan systems.

Providing uniform year 'round temperature together with foolproof individual room control has always been a problem in designing buildings of this nature. But Scott & Kinney provided the solution in their selection and imaginative arrangement of a Powers Pneumatic Control System.



Building "G", University of Kansas Medical Center

ARCHITECTS:
Kansas State Architectural Dept., Topeka, Kansas

CONSULTING ENGINEERS:
Scott & Kinney, Kansas City, Missouri

MECHANICAL CONTRACTOR:
A. D. Jacobson Plumbing & Heating, Inc., Kansas City, Missouri

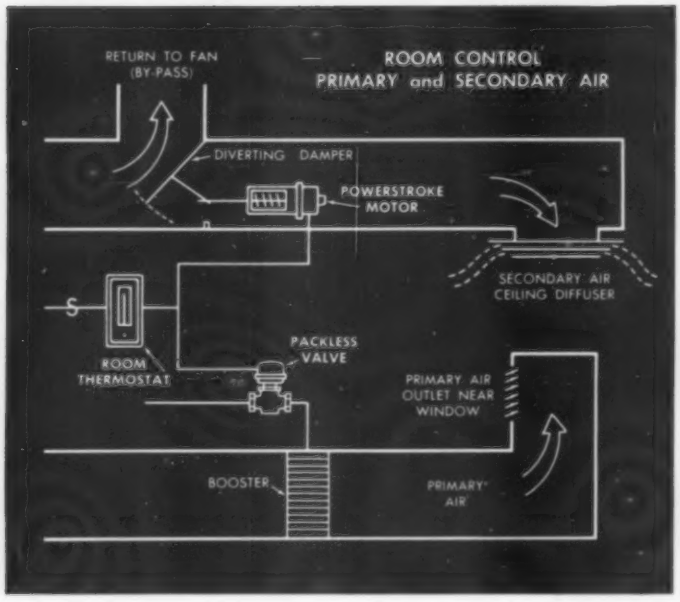
Final check on the U. of K. Psychiatry Building's pneumatic control system by the consulting engineers, Wilson O. Kinney (left) and Arthur R. Scott.

Heating, ventilating and air conditioning are accomplished through primary and secondary air systems. The primary system operates throughout the year, supplying a small amount of circulated air, including outside air. Final control in the primary system is a reheat coil — one for each patient room — using hot water with a Powers modulating packless valve.

Heart of the secondary — or booster — system is the automatic, quick-acting diverting damper. It permits both fresh and refrigerated air to pass into the individual rooms through a ceiling diffuser. When cooled air is not needed, it is diverted automatically by the damper into the ceiling plenum for return to the secondary fan.

To simplify individual room control of temperature, Scott & Kinney coordinated the actions of the reheat coil and the auto damper into a single control. One thermostat in each room controls both for maximum comfort.

This imaginative handling of standard Powers temperature control equipment is another example of problem-solving by the consulting engineer and the specialized help of Powers field engineers. The University of Kansas has reaped the benefits for the last four years — in comfort, operating economy and low cost maintenance.



For more ideas and technical data on Powers pneumatic temperature control equipment and systems, write for the latest Powers Catalog.

TIME and MONEY-SAVING
PNEUMATIC TUBE SYSTEMS FOR HOSPITALS . . .

Write for this informative booklet on pneumatic tube systems designed to handle any load . . . any capacity . . . to suit any hospital. These automatic tube systems are manufactured by our new subsidiary, The Grover Company.

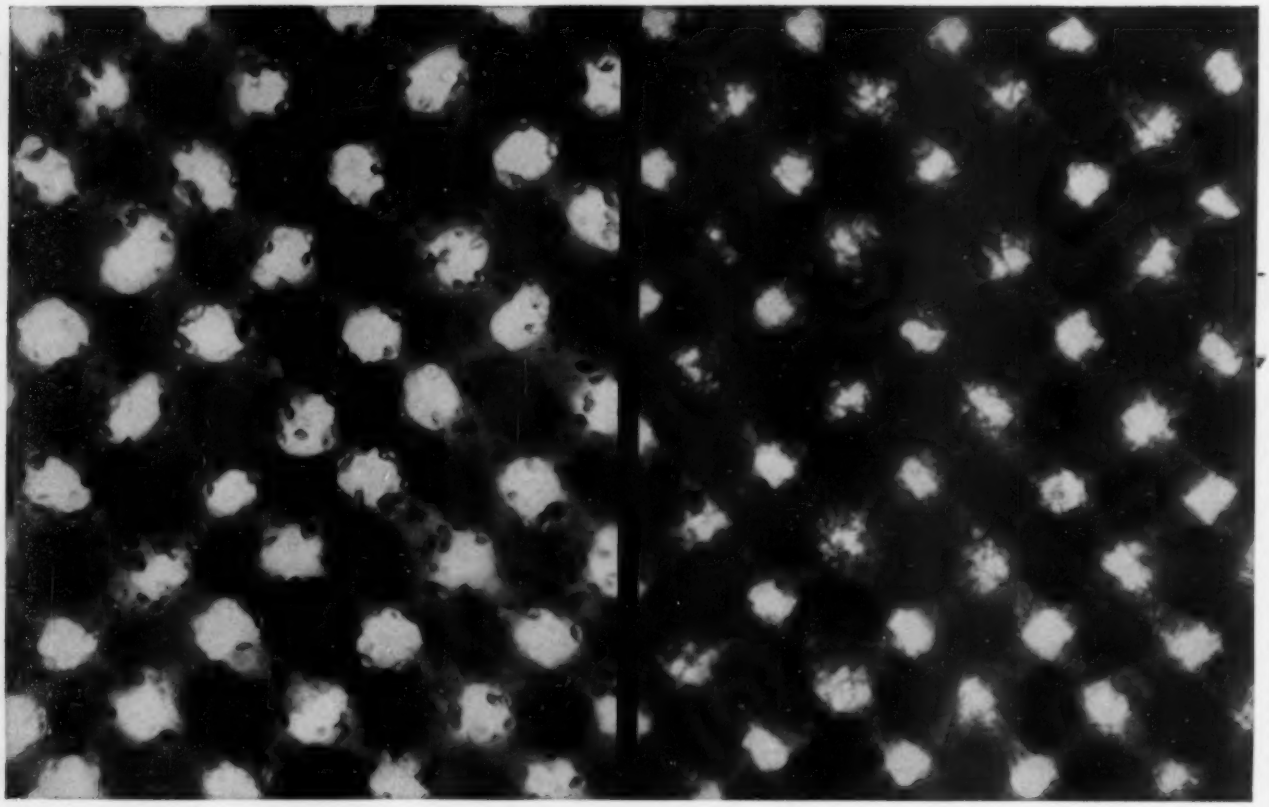
THE POWERS REGULATOR COMPANY

DEPT. 561, SKOKIE 57, ILLINOIS / *Offices in Principal Cities of U.S.A. and Canada*

MANUFACTURERS OF THERMOSTATIC CONTROLS SINCE 1891

Now with Velva-Soft-G

hospital linens can fight infections



These companion photomicrographs show Velva-Soft-G's effective antibacterial control on a laundered sheet placed in a suitable medium seeded with Staphylococci. At left is the untreated sheet with dark "staph" colonies growing profusely. At right is the sheet treated with Velva-Soft-G. This picture clearly shows that Velva-Soft-G inhibited bacterial growth.

What Velva-Soft-G is:

It is a special cationic fabric softener with specific antibacterial chemicals to control a wide spectrum of germs, including the antibiotic-resistant strains of Staphylococcus aureus. Because of its cationic charge, Velva-Soft-G readily attaches itself to fabric when it's applied in the last cycle of the laundering operation.

Why it was developed:

Resistant strains of Staphylococcus aureus are held responsible for patient infection in many hospitals. Velva-Soft-G was developed to help hospitals' over-all environmental sepsis program—by controlling the spread of organisms on lint. The final formula evolved from variations tested on approximately three million pounds of hospital-washed linens.

How it controls germs:

Effective with the first application, Velva-Soft-G does two important things. (Regular laundering techniques do not do them.)

1. It gives fabric an antibacterial shield which remains effective even in prolonged storage. Velva-Soft-G effectively inhibits bacterial growth all the time linens are used. It continues to be effective in the crucial time when linens are being returned for re-washing and re-treatment.

2. It substantially reduces the incidence of air-borne infection through lint control. Bacteria literally ride on the lint particles from patient to patient. Lint is caused by fiber breakage. Velva-Soft-G's lubricity reduces fiber breakage and subsequent lint formation.

Velva-Soft-G does even more:

It softens all fabrics to increase patient comfort. It eliminates ammonia formation and odor in urine-soiled linens. Velva-Soft-G controls many strains of mildew-causing fungi which can be a problem when soiled, damp linens are stored prior to washing.

It is not toxic to patients:

Hospitals have evaluated Velva-Soft-G on linens used for many months without finding a single case of dermal sensitization due to Velva-Soft-G.

It is economical:

The cost is less than 3¢ per patient, per day. This should be considered in view of the objective of controlling infection on all hospital-treated linens. Velva-Soft-G can provide certain operating economies, too. It makes the laundry load easier to handle; reduces extraction and drying time; and eliminates static electricity for faster feed through the flatwork ironer. In addition, all treated fabrics will have a longer wear life because Velva-Soft-G's fiber lubricity reduces breakage.

Organism Counts on Treated and Untreated Linens*

*Upper figure represents beginning of operation, lower figure the end.

Treatment	Suds 1st	Suds 2nd	1st	2nd	3rd	4th	Sour Bath	Over-all Avg.
Total Organisms per Ml.*								
1. *Water Only* (no load)	1 1	1 1	0 0	1 2	4 4	1 2		1.5
2. *Regular Load* (bed jackets) Never treated with germicide	130 130	20 22	180 170	130 110	225 110	165 290	320 200	155.0
3. *Regular Load* (bed jackets) Treated with Velva-Soft-G before patient use	1 0	0 0	1 1	2 1	3 2	1 0	0 0	0.9

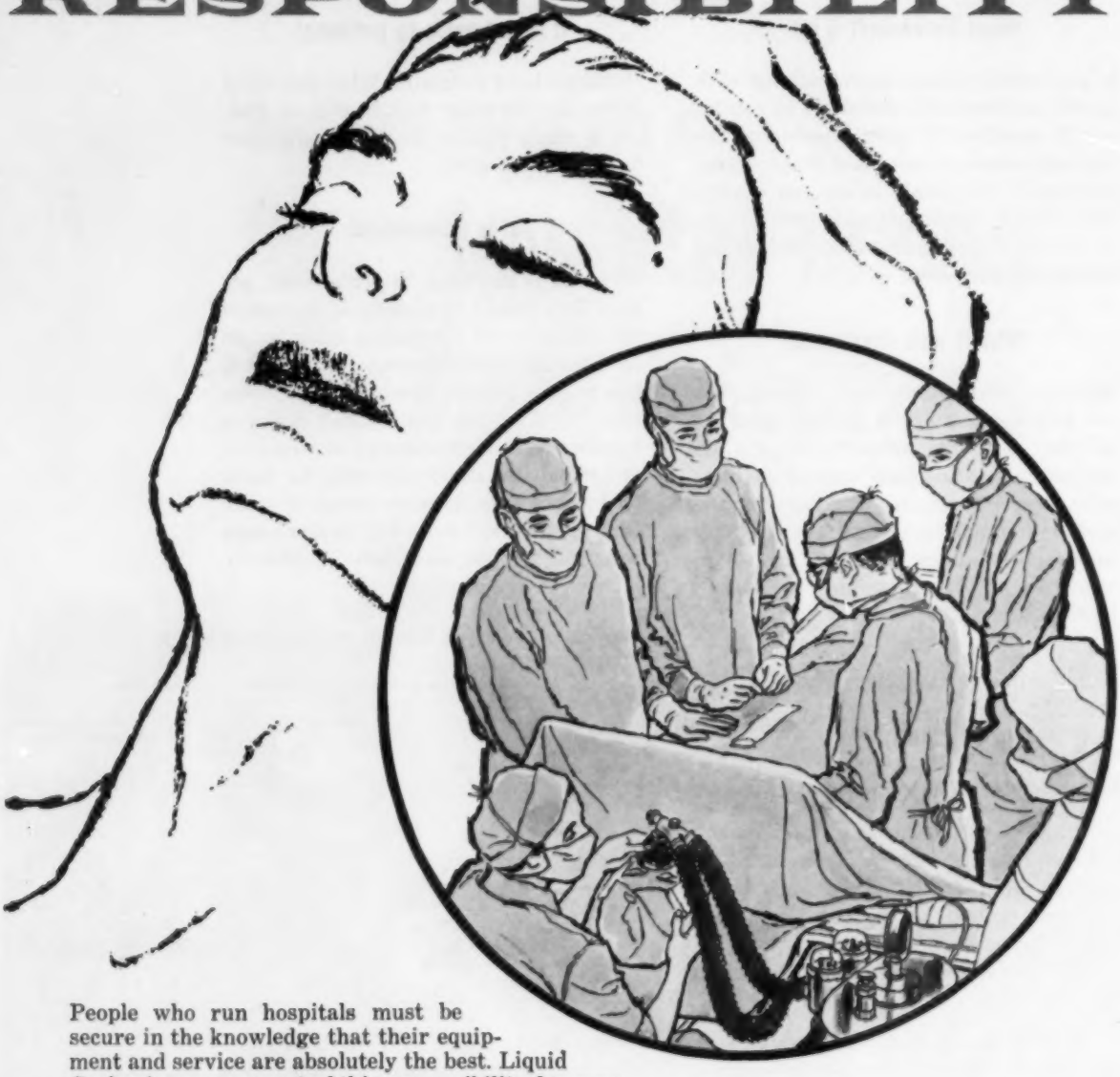
The over-all average indicates that Velva-Soft-G apparently reduced the high growth of organisms to the virtually germ-free level of the tap water.

For technical information on clinically-proven antibacterial treatment for hospital linens with Velva-Soft-G, please write: B. J. Augst, Manager, Industrial Soap Division, Armour and Company, 1355 West 31st Street, Chicago 9, Illinois.

ARMOUR AND COMPANY

Industrial Soap Division
1355 West 31st Street
Chicago 9, Illinois

RESPONSIBILITY



People who run hospitals must be secure in the knowledge that their equipment and service are absolutely the best. Liquid Carbonic assumes part of this responsibility for you:

. . . with medical equipment built to perform dependably year after year

. . . with medical gases whose purity requirements exceed U.S.P.

. . . with complete Liqui-Med central supply systems and related equipment for piping oxygen, nitrous oxide, vacuum and air

. . . with a corps of highly trained field representatives to help solve your problems.

Patients in need of reliable anesthetics . . . safe oxygen tents . . . dependable respirators . . . or any medical equipment . . . place their faith in the medical profession.

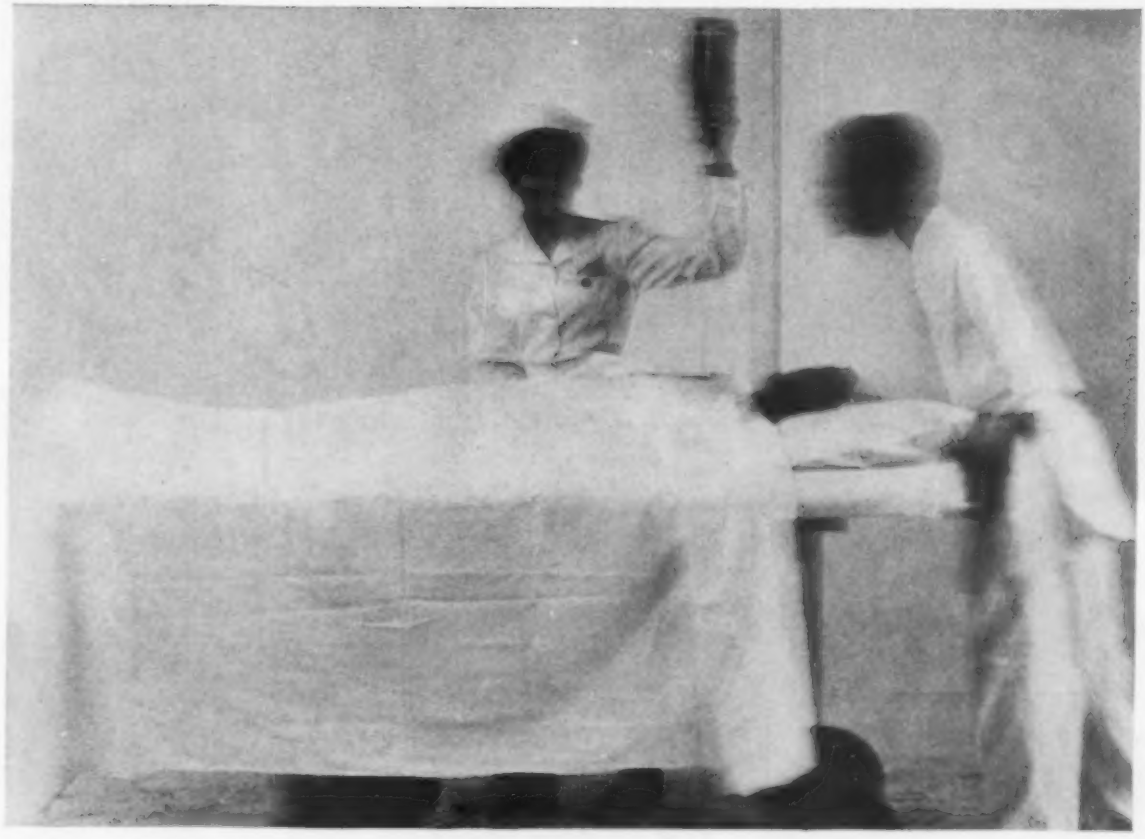
These lives are your responsibility.

They are our responsibility, too—because your responsibilities are our business.

LIQUID CARBONIC
DIVISION OF **GENERAL DYNAMICS**

Dept. MH, 135 South LaSalle Street, Chicago 3, Illinois
In Canada: Liquid Carbonic Canadian Corporation, Limited
8375 Mayrand Street, Montreal 9, Quebec

when standard antishock measures fail



Indications and effects: Solu-Cortef is indicated when intense corticosteroid effect is necessary in various situations including acute adrenal cortical insufficiency, bilateral adrenalectomy, shock unresponsive to standard antishock therapy, acute hypersensitivity reactions, disseminated lupus erythematosus in relapse, and overwhelming infections with severe toxicity. *Administration and dosage:* Sterile Solu-Cortef may be administered intravenously or intramuscularly, the intravenous route being preferred in emergencies. The initial dose is 100 mg. or 250 mg., depending on the severity of the condition, injected over a period of one-half to one minute. This dose may be repeated at intervals of one, three, six and ten hours, depending on the response and clinical condition.

Precautions and contraindications: Careful management is required, especially during sustained therapy, to guard against untoward manifestations such as sodium retention, edema, excessive potassium loss, and negative nitrogen balance. Solu-Cortef is contraindicated (except for emergency replacement therapy in acute adrenal cortical insufficiency) in patients with tuberculosis, herpes simplex keratitis, chronic nephritis, acute psychosis, Cushing's syndrome, peptic ulcer, and predisposition to thrombophlebitis. Existence of congestive heart failure, hypertension, diabetes, osteoporosis, or chronic psychiatric disorders requires that Solu-Cortef be administered with extreme caution. In the presence of infection, the causative organism must be brought under control with appropriate antibiotics; otherwise Solu-Cortef should be discontinued.

Supplied: In 2 cc. Mix-O-Vial® containing 250 mg. or 100 mg. hydrocortisone (as hydrocortisone sodium succinate), and in 10 cc. vial containing 100 mg. hydrocortisone (as hydrocortisone sodium succinate) per vial.

100 mg. (plain vial)
Each vial contains:

Hydrocortisone (as hydrocortisone sodium succinate)	100 mg.
Sodium biphosphate	0.8 mg.
Sodium phosphate, exsiccated	8.73 mg.

Also available in carton with one 2 cc. ampoule injectable sterile water.

250 mg. Mix-O-Vial
Each Mix-O-Vial contains:

Hydrocortisone (as hydrocortisone sodium succinate)	250 mg.
Sodium biphosphate	2 mg.
Sodium phosphate, exsiccated	21.83 mg.
Methylparaben	2.34 mg.
Propylparaben	0.27 mg.
Water for Injection	1.8 cc.

100 mg. Mix-O-Vial
Each Mix-O-Vial contains:

Hydrocortisone (as hydrocortisone sodium succinate)	100 mg.
Sodium biphosphate	0.8 mg.
Sodium phosphate, exsiccated	8.73 mg.
Methylparaben	2.34 mg.
Propylparaben	0.27 mg.
Water for Injection	1.8 cc.

In shock resulting from trauma, surgery, or overwhelming infection, Solu-Cortef® triggers vasopressor effects. As a result, patients often respond to Solu-Cortef when standard antishock measures have failed.

®Trademark, Reg. U. S. Pat. Off.

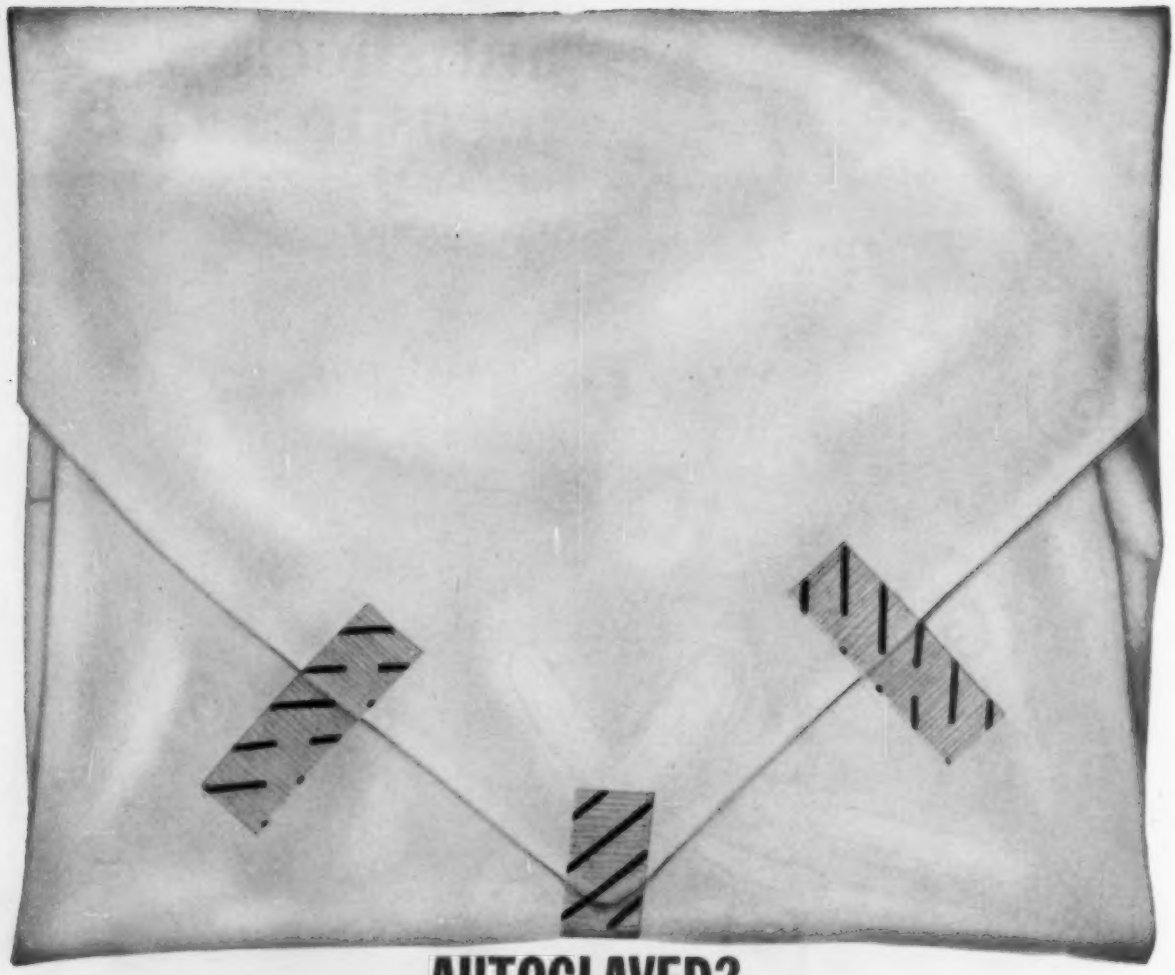
restore and maintain hemodynamics with

Solu-Cortef

I.V. HYDROCORTISONE

Upjohn

The Upjohn Company
Kalamazoo, Michigan



AUTOCLAVED? YOU CAN BE SURE!

There is no doubt when you seal bundles and containers with "SCOTCH" Brand Autoclave Tape No. 222. Dark lines appear on the tape only after exposure to correct levels of heat and moisture in an autoclave. Any other heat and/or moisture exposure cannot activate the tape. "SCOTCH" Autoclave Tape holds fast before, during and after autoclaving . . . applies easily . . . sticks at a touch to paper, cloth, glass, metal . . . leaves no residue. "SCOTCH" Autoclave Tape is faster to use than pins, string, cotton plugs, and may be easily marked with pen, pencil or typewriter.

New! For gas sterilizers!

Now, secure sealing and positive identification of gas sterilized bundles are made possible with new "SCOTCH"Brand Ethylene Oxide Sterilizer Tape No. 224. This tape offers the same assurance of proper exposure that "SCOTCH" Brand Tape No. 222 does in steam autoclaves. For complete details, contact your surgical supply dealer, or write 3M Company, St. Paul 6, Minnesota.

(Note: Each of these tapes is designed for a specific purpose. The Autoclave Tape will not function in a gas sterilizer; nor will the Ethylene Oxide Tape function in a steam autoclave. Nothing on the outside of an autoclaved or gas-sterilized item, of course, can guarantee sterility of contents.)

"SCOTCH"® BRAND HOSPITAL AUTOCLAVE TAPE NO. 222

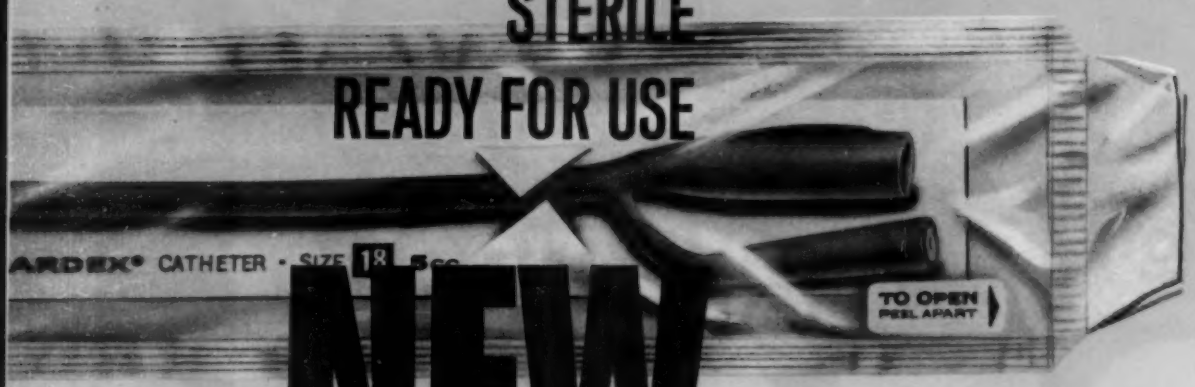
"SCOTCH" is a registered trademark of 3M Co. ©3M Co., 1961

MINNESOTA MINING AND MANUFACTURING COMPANY 3M

...WHERE RESEARCH IS THE KEY TO TOMORROW

For additional information, use postcard facing back cover.

STERILE
READY FOR USE

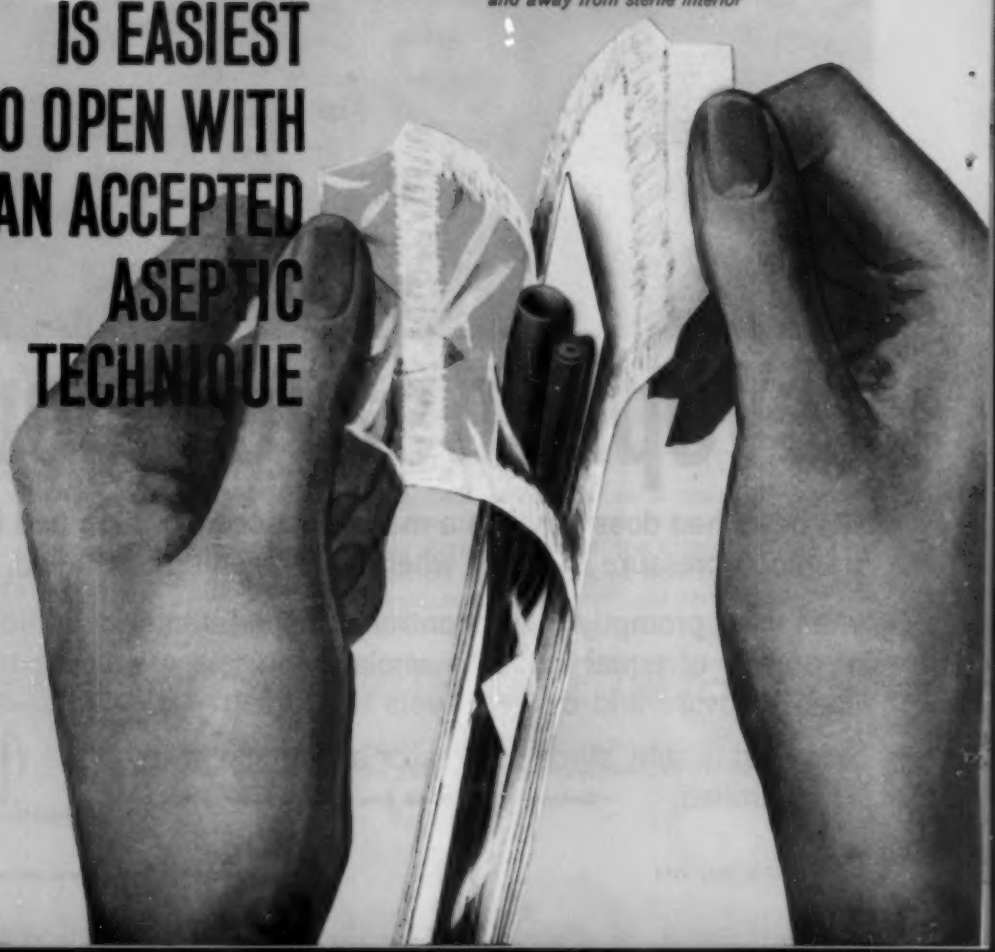


NEW

STERIL-PEEL

PACKAGE IS EASIEST TO OPEN WITH AN ACCEPTED ASEPTIC TECHNIQUE

To open, simply pull tabs back and away from sterile interior



ANOTHER BARD FIRST

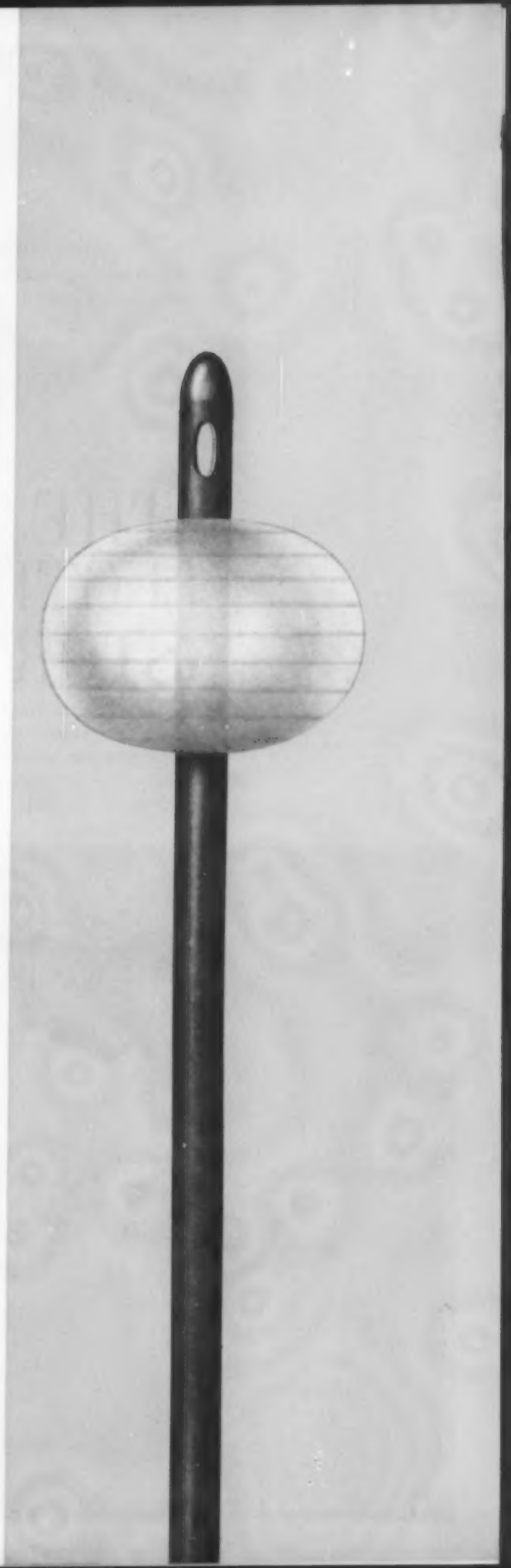
STERIL-PEEL™...THE MOST EFFICIENT PACKAGE FOR BARDEX®...THE FINEST FOLEY CATHETER

Bardex®—the Foley Catheter with features that ensure dependable performance...reinforced ribs to provide even distention of the balloon...multiple dipping in premium latex to produce a uniform wall thickness; large, smooth eyes for maximum drainage. These are some of the reasons why hospitals willingly pay a little more, and why they continue to specify more Bardex Foley Catheters than all other brands combined!

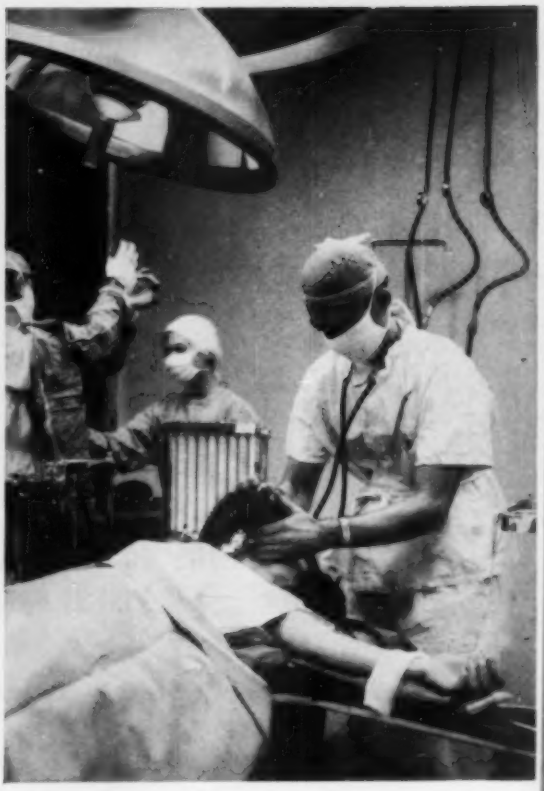
Sterile-packaged Bardex catheters are now available in this new and exclusive tab-opening, peel-apart package; at no increase in cost. Ready for instant use, the new "Steril-Peel" package provides a simple and instrument-free aseptic opening technique that has been evaluated and approved by leading hospitals..."Steril-Peel" is another good reason to specify BARDEX® FOLEY CATHETERS

C. R. BARD, INC. • SUMMIT, N. J.

QUALITY INTEGRITY SERVICE
BARD
SINCE 1907



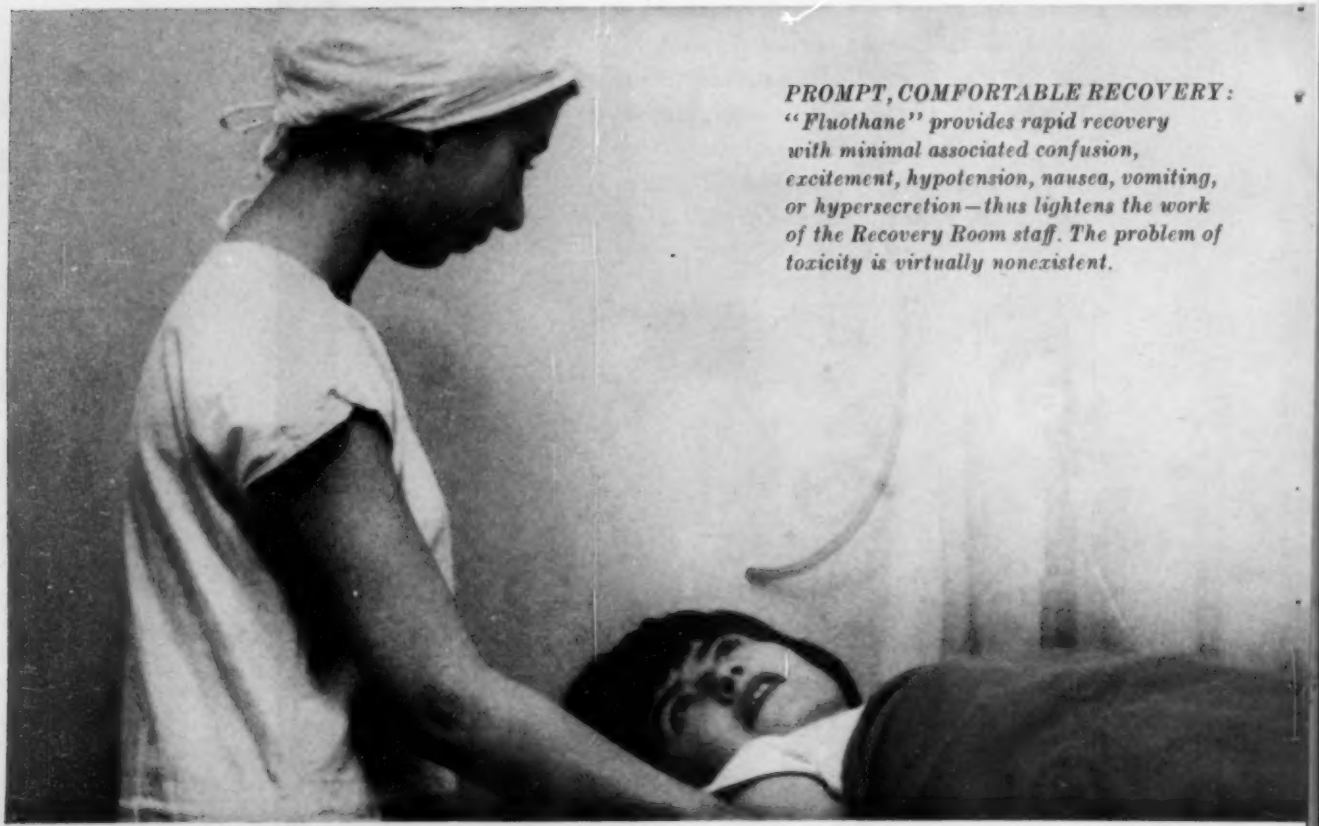
RAPID, SMOOTH INDUCTION:
"Fluothane" anesthesia proceeds from rapid induction into the desired anesthetic plane. The patient quickly goes through Stage II, with few or no signs of excitement.



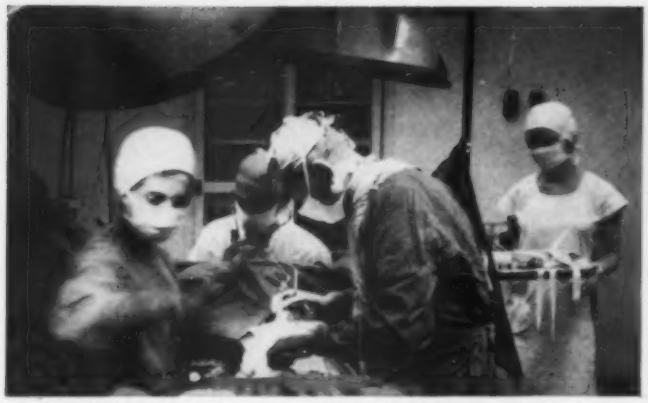
THE "FLUOTHANE" STORY

AYERST LABORATORIES
New York 16, N. Y.
Montreal, Canada

Ayerst Laboratories make "Fluothane" available in the United States by arrangement with Imperial Chemical Industries, Ltd.



PROMPT, COMFORTABLE RECOVERY:
"Fluothane" provides rapid recovery with minimal associated confusion, excitement, hypotension, nausea, vomiting, or hypersecretion—thus lightens the work of the Recovery Room staff. The problem of toxicity is virtually nonexistent.



PRECISE, EFFECTIVE, RAPIDLY REVERSIBLE ANESTHESIA: The anesthetic plane is easily maintained, easily lightened or deepened. Cardiorespiratory difficulties are rarely encountered, readily corrected. Due to increased flexibility of depth of anesthesia, the surgeon enjoys greater freedom in selecting a specific operative technic.

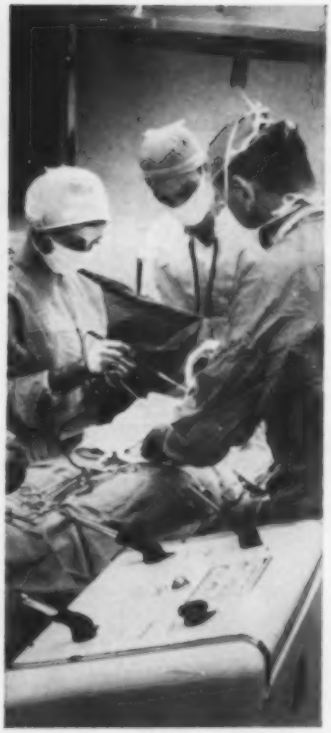
"Fluothane"®

Brand of Halothane

PRECISION INHALATION ANESTHETIC

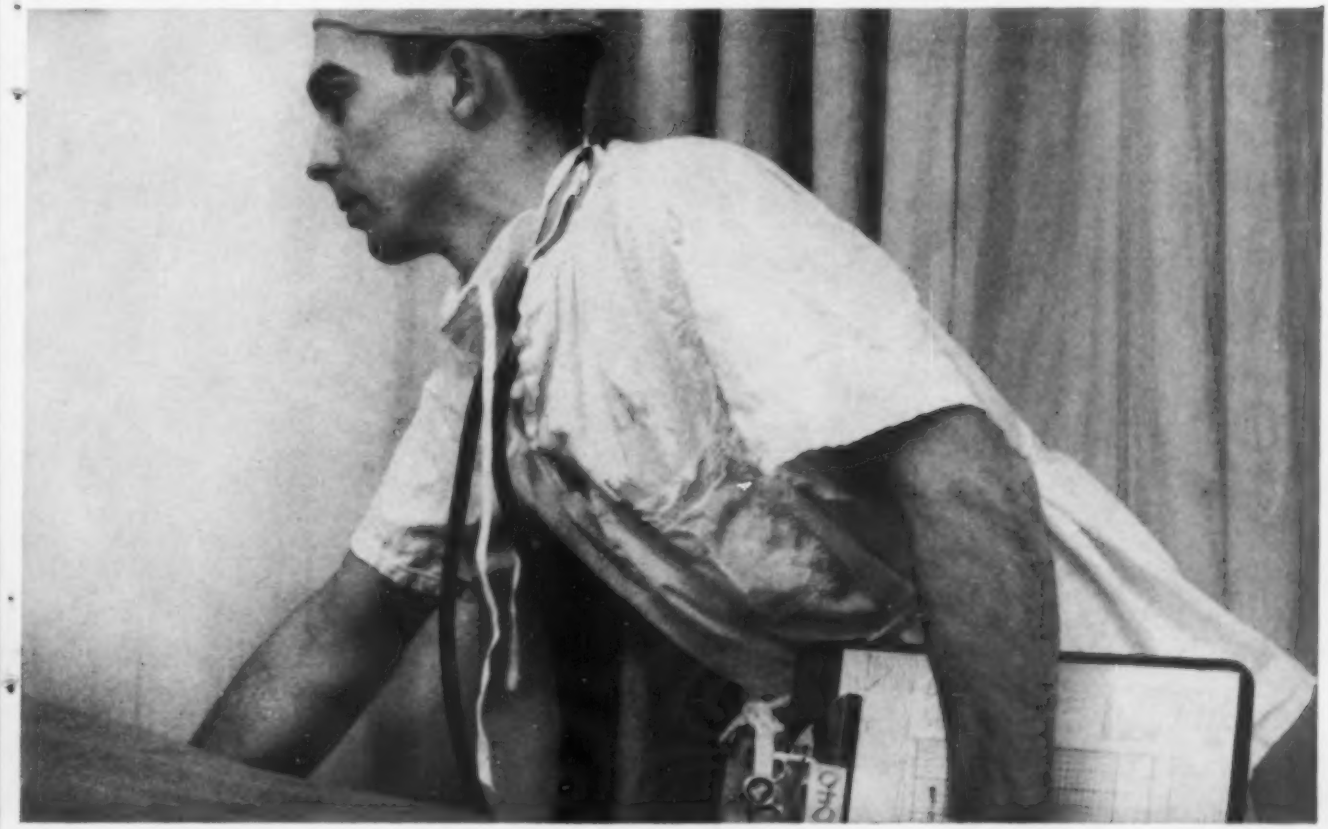
Because "Fluothane" is markedly potent, it should be administered by a qualified anesthesiologist who is sufficiently familiar with its characteristics to take the necessary precautions. A vaporizer accurately calibrated to deliver precise concentrations, that may be altered in fractions of 0.1 per cent over a clinical range of 0.5 per cent to 3.5 per cent, should be used. The recommended technics and precautions for administering "Fluothane" are immediately available in the insert accompanying the unit package.

Supplied: No. 3125—Unit package of 125 cc. of Halothane stabilized with 0.01% Thymol (w/w).



NONFLAMMABLE, NON-EXPLOSIVE: "Fluothane" can neither ignite nor explode. Where inhalation anesthesia is indicated, the surgeon is unrestricted in the employment of cautery or X-ray equipment.

6119

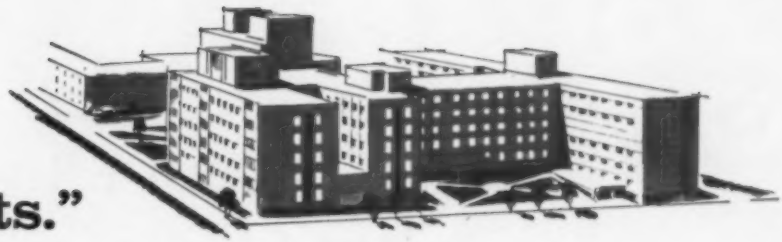


Mr. Bryce L. Twitty, Administrator of
Hillcrest Medical Center, Tulsa, Okla., says:

"Honeywell thermostats on the wall nurses for more important duties and

Mr. Twitty stands in the bedroom of a two-room private suite—a new innovation at Hillcrest Medical Center.

relieve our help cut costs."



HILLCREST MEDICAL CENTER, TULSA, OKLAHOMA
North Wing—Boiler Plant: Donald McCormick, Architect
H. Lyman Cauvel, Engineer
Mabee Children's Wing: Hugh Humphries, Architect
Carnahan & Thompson, Engineers

Individual room thermostats free nurses from chambermaid chores. And a Honeywell DataCenter keeps a constant watch over the entire heating-cooling system.

"Because our payroll is the largest part of our budget, anything we can do to relieve our nurses of time-consuming chambermaid chores is a cost savings. Thanks to the alert planning of our architects and engineers, we have realized such a savings by installing Honeywell individual room thermostats. They eliminate such jobs as opening and closing windows and procuring blankets—thus freeing the nurses to attend to more important duties. In addition, our heating costs can be reduced because thermostats in vacant rooms can be turned down."

Honeywell has also installed a Supervisory DataCenter* at Hillcrest. Through a panel in the building engineer's office, the entire heating-cooling system can be checked and adjusted. The engineer can check humidity and temperature in surgery, in delivery rooms, in nurseries and in any floor or wing of the hospital. An alarm system is also provided for the oxygen and nitrous oxide systems.

Hillcrest Medical Center has been in operation since 1918. The present expansion, which includes the Mabee Children's Hospital, North Wing and Nurses' Residence, is the largest single building project in its history. Presently, plans are being completed for a new psychiatric clinic. Each of the new buildings will be controlled by the Honeywell DataCenter. The older Hillcrest buildings will also be controlled by the DataCenter.

The DataCenter eliminates constant trips throughout the hospital and assures the finest, most economical comfort at all times.

To learn how Honeywell Controls can help reduce the costs of operating your hospital, see your architect or engineer. Or call your nearest Honeywell office. If you prefer, write to Honeywell, Dept. MH-5-173, Minneapolis 8, Minnesota. **Trademark*

Newly installed Honeywell DataCenter will eventually control entire heating-cooling system for all Hillcrest buildings.

Honeywell

First in Control

SINCE 1885

HONEYWELL INTERNATIONAL
Sales and service offices in all principal cities of the world. Manufacturing in the United States, United Kingdom, Canada, Netherlands, Germany, France, Japan.

ULTRAMODERN BRASÍLIA, TOO, CHOOSES PENTOTHAL

Yesterday, here stood only waisthigh grasses of a trackless savanna. Today, skyscraper pinnacles thrust upward in one of the world's most advanced concepts of city planning.

Near Brasília's heart is placed one of its proudest elements, a magnificent hospital center. Here, as you would expect, Pentothal is an anesthetic of choice. The reasons are the same that have made it a favorite in 75 other lands:

Ease and rapidity of induction.
Absence of delirium (Stage II of anesthesia).
Rapid emergence from unconsciousness.
Relative freedom from postoperative nausea, vomiting.
Relative absence from respiratory irritability.
Ability to rapidly increase narcosis.
Freedom from fire and explosion hazard.

These same reasons can make Pentothal equally useful to you and your own hospital. Your Abbott representative will be glad to supply full details on this product.

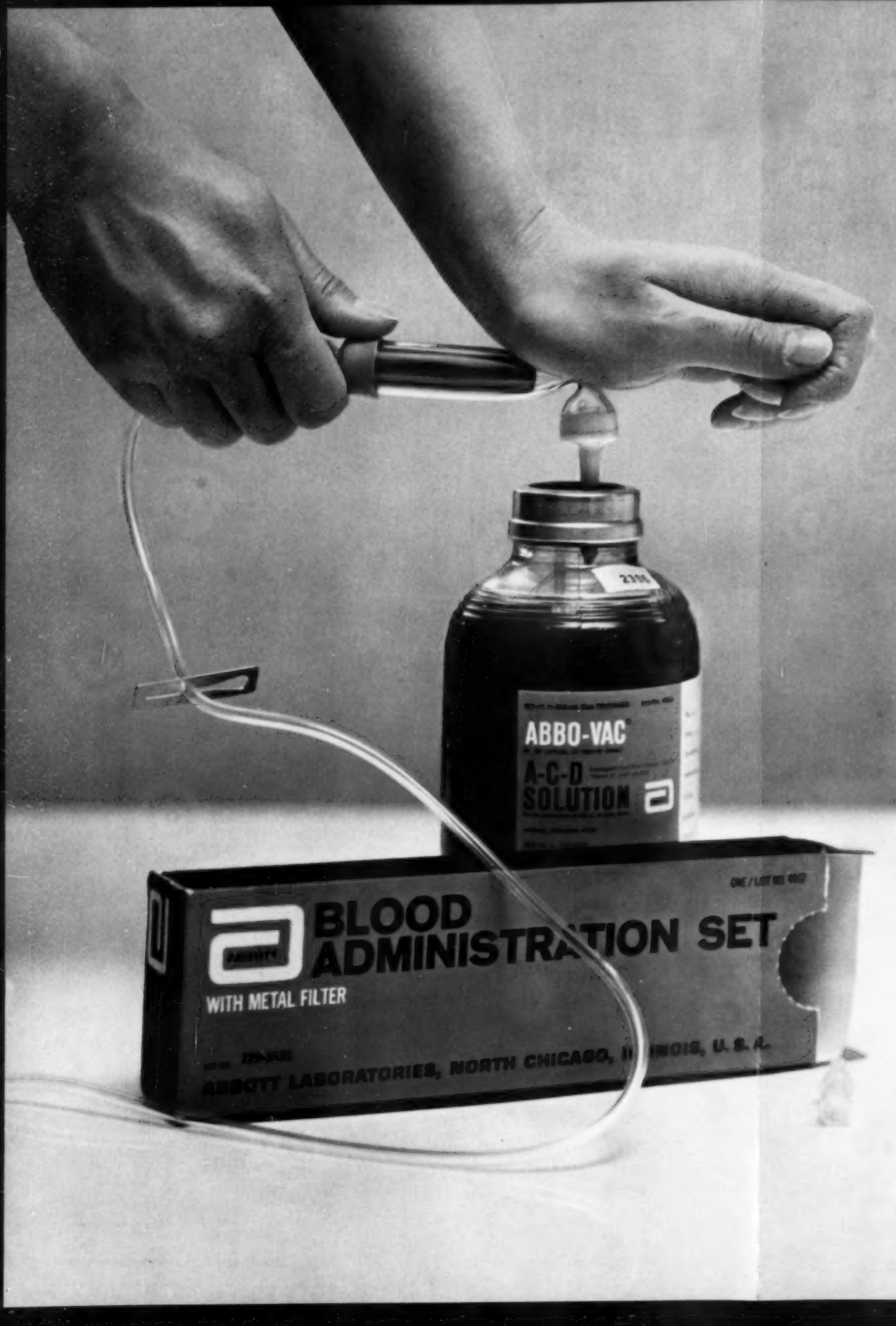
PENTOTHAL® sodium

(Thiopental Sodium, Abbott)

Over 3200 world reports attest to the efficacy of PENTOTHAL

ABBOTT

BRASÍLIA (opposite page), by South America's Juan Carlos Colevatti, is available in wide margins for framing. Write Professional Services, Abbott Laboratories, North Chicago, Illinois.


ABBO-VAC
A-C-D
SOLUTION
BLOOD
ADMINISTRATION SET
WITH METAL FILTER
ABBOTT LABORATORIES, NORTH CHICAGO,

ABBOTT SETS ARE BUILT TO TAKE IT

Abbott Blood Administration Sets are built to stand up under punishment. Heavy-duty construction is used everywhere. Tough, heavy-gauge polyvinyl is specified for the tubing and chamber housing. The fused joints test even stronger than the material itself. The piercing cannula is molded of high-impact acrylic. The metal filter is permanently imbedded into the chamber at white heat. All parts are inspected, re-inspected, and inspected again.

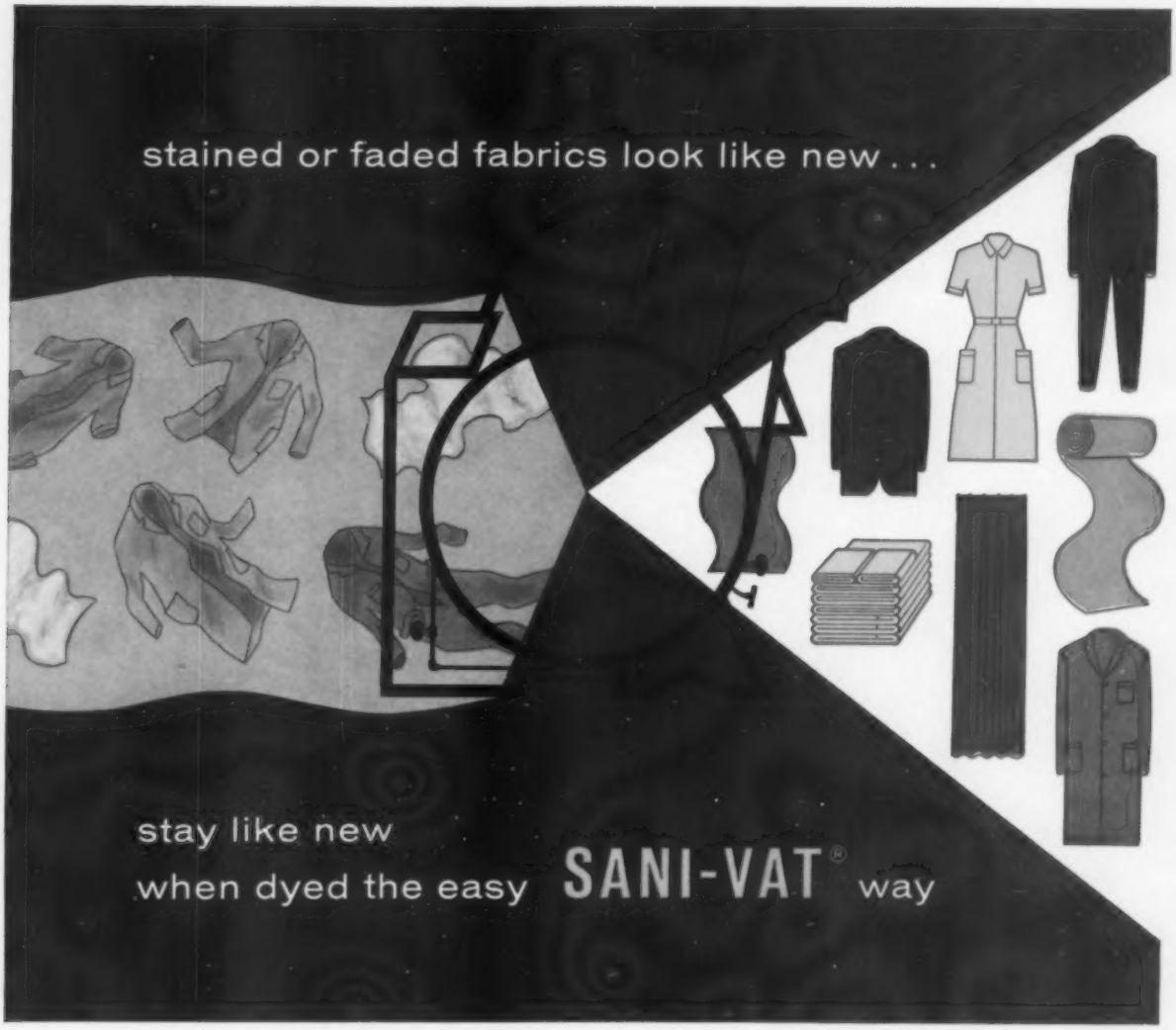
Abbott sets are built to keep running when the going gets tough, too. While almost any set can transfuse fresh blood, the real test comes in handling stored blood, with its possible fibrin content. Here's where Abbott's exclusive filter design pays off. The mesh—over four square inches—is made of Monel metal, whose hard, uniform strands afford no fewer than 2800 openings of precise diameter. The smooth metal surface is siliconed for non-wettability. This high performance mesh—plus the prestraining cannula—assures the most dependable filtration possible.

If debris begins to accumulate, the flexible chamber can be squeezed to clear it without dismantling the set, or disturbing the patient.

Now, for your added convenience, Abbott offers new extra-length Blood Administration Sets. 78 full inches give you ample reach at bedside or surgery.

Remember, too, the helpful variety of styles available from Abbott: primary, secondary, Y-type, controlled volume, and inline blood pump administration sets. Your Abbott man will gladly demonstrate. See him soon.

ABBOTT



For hospitals, hotels, motels, linen supply houses, restaurants, air lines, pullmans and ships

You can use it in your own laundry equipment . . . quick, easy and low in cost

Bright, attractive new look—Linens, uniforms, work clothes, drapes, rugs—stained, faded or otherwise unserviceable—acquire an entirely new appearance when dyed the SANI-VAT way. This economical vat dye system extends the useful life of your fabrics. It can be used not only for its decorative effects, but also for color-coding.

Excellent fastness—During the dyeing cycle, the SANI-VAT pigment is locked within the fibers . . . resulting in extreme fastness to washing, sun light, bleaching, dry cleaning and hot pressing.

Consistently even dyeing—SANI-VAT's superior dispersion properties allow instant and streakless penetration of dye into fabrics . . . producing consistently uniform coloring.

Easy-to-use—Anyone using your laundry equipment can easily follow the simple instructions included in the conveniently packaged SANI-VAT Kit . . . and do a quality job.

Wide range of colors—SANI-VAT Dyes are readily available in a wide range of lasting colors—dark shades to pastels.

Write for this free booklet on low-cost, easy-to-use SANI-VAT Dyes. Just fill in and mail coupon today!

☐ Please send a copy of the free SANI-VAT Dye Booklet.

☐ Please have a sales representative call on me.

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Street_____

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Mail to: Chemicals and Dyestuffs Division, Koppers Company, Inc., Koppers Building, Pittsburgh 19, Pennsylvania.

KOPPERS COMPANY, INC.

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PINKERTON'S INVESTIGATIVE SERVICE CONTROLS COSTLY PILFERAGE

An experienced Pinkerton investigator can solve problems which lie outside the scope of the regular supervisory staff. In such matters as theft of linens, drugs and narcotics, even dissatisfaction on the part of patients and their families, an outside investigator, ostensibly working as an orderly or cook, can soon get to the source of the trouble. One of our investigators, for example, working in a hospital laundry, found that workers were taking out linens in quantities sufficient to stock and operate a small store! Should you suspect that thefts or discourtesies are impairing the smooth functioning of your institution, we recommend that you consult Pinkerton's, the oldest and largest investigative and security organization in America. Write for brochure "Institutional Security."

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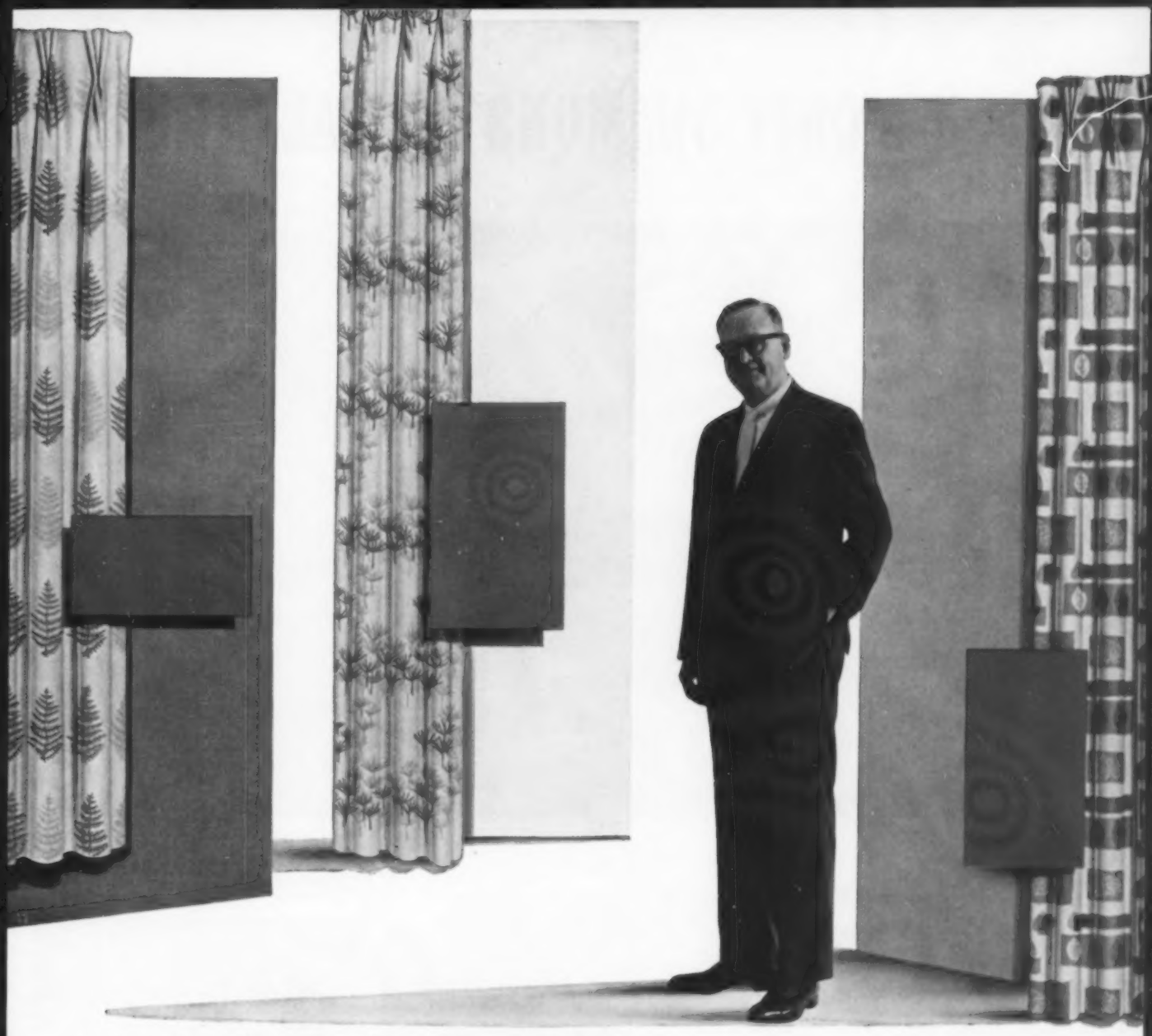

Colin Campbell McLean, Official Decorator AHA, recalls:

"I learned the Beneficial Value of Color *the hard way*"

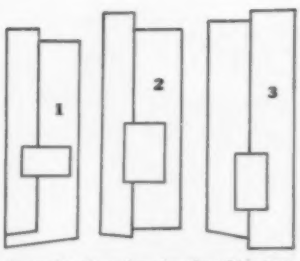

Illustration above shows how Pratt & Lambert New Lyt-all Flowing Flat Calibrated Colors, co-ordinated with draperies and fabric coverings, result in completely color-balanced rooms.

1. P&L PARCHMENT
2. P&L SPROUT
3. P&L DUSTY GREEN

"Over 20 years ago I was confined to a dismal hospital for ninety long days. It was a hard way to learn that hospitals should be *humanized*...with pleasing color harmonies. Color, like music, has a tremendous emotional appeal.

"The beautiful Western Pennsylvania Hospital in Pittsburgh is an excellent example of how this theory was applied. A few of the color harmonies for patients' rooms are shown above. They reflect the cheerful, considerate care provided there.

"To assure exquisite harmonies of painted interiors, we have always recommended Pratt & Lambert 'Calibrated Colors®'. Color has three dimensions—hue, chroma and value. Pratt & Lambert has skillfully calibrated these, color by color, to make possible harmonies that are particularly right."

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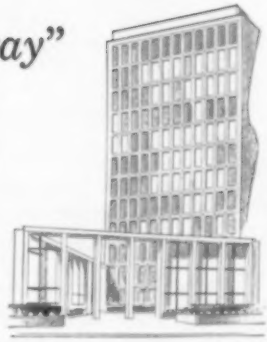
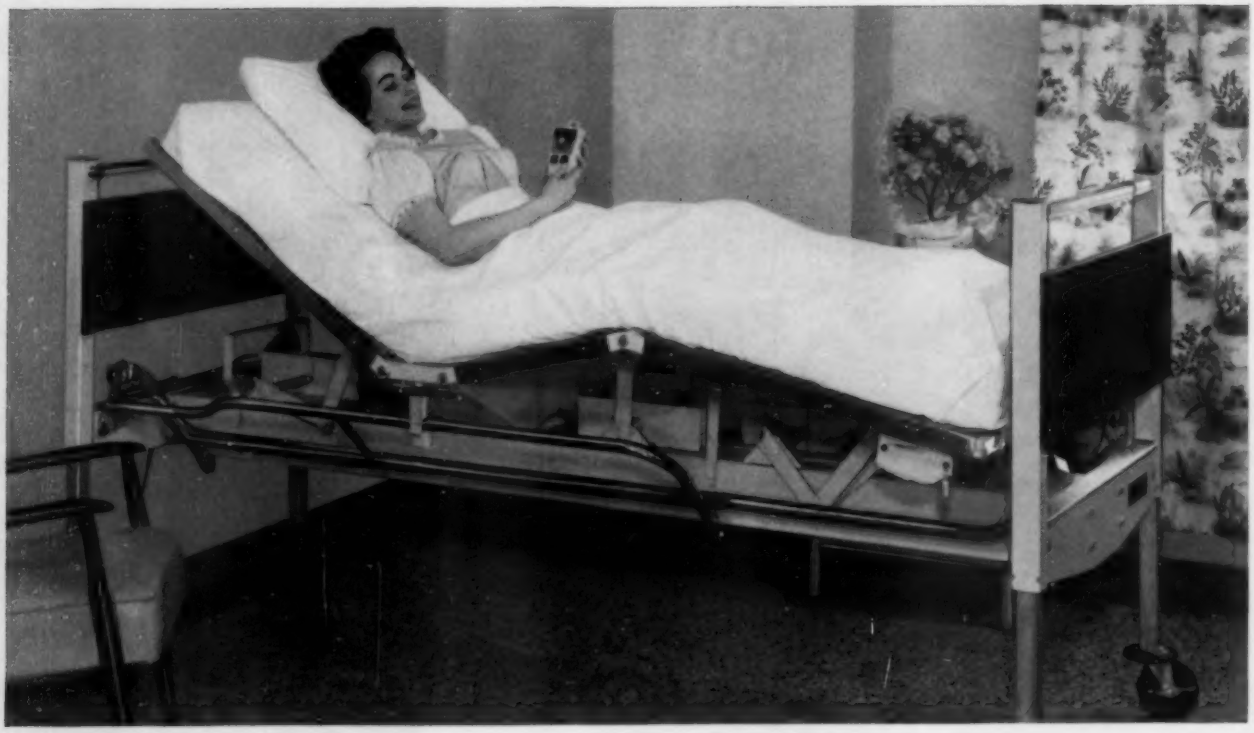


Colin Campbell McLean has applied his theories on color in hospitals throughout the country, and in the magnificent American Hospital Association Building in Chicago, illustrated above. He is the dynamic head of Hospital Furniture Inc., a Chicago consulting firm on hospital decoration. Mr. McLean is the official decorator for the American Hospital Association and the American College of Hospital Administrators.

ONLY SIMMONS HAS ALL THESE

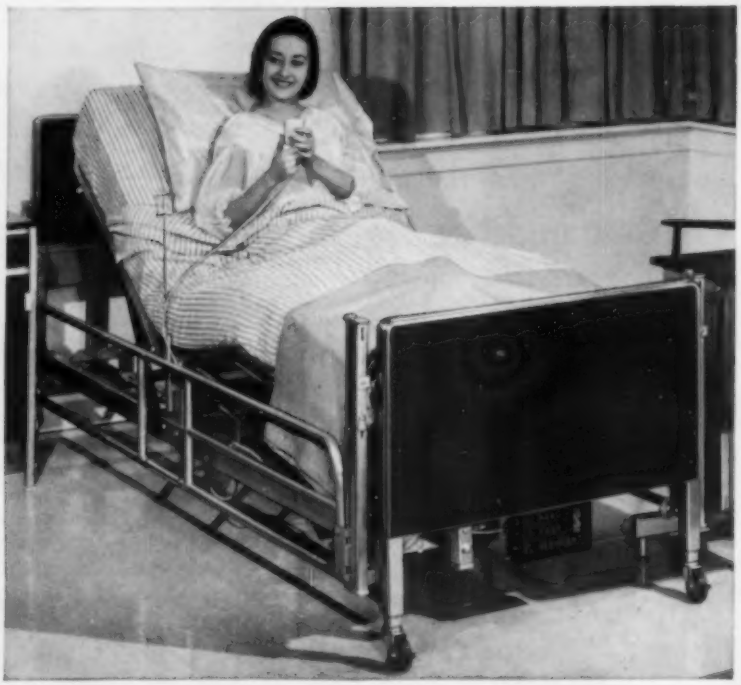


MULTI-MATIC

Has eight distinct motorizing actions. Adjusts to any prescribed medical position. Patient selects desired position with easy-to-operate hand control. Nurse controls bed height. Extra-length spring for tall patients. All-steel construction with extra-rigid legs. Removable head and foot panels; out-of-the-way storage space for side rails, other accessories.

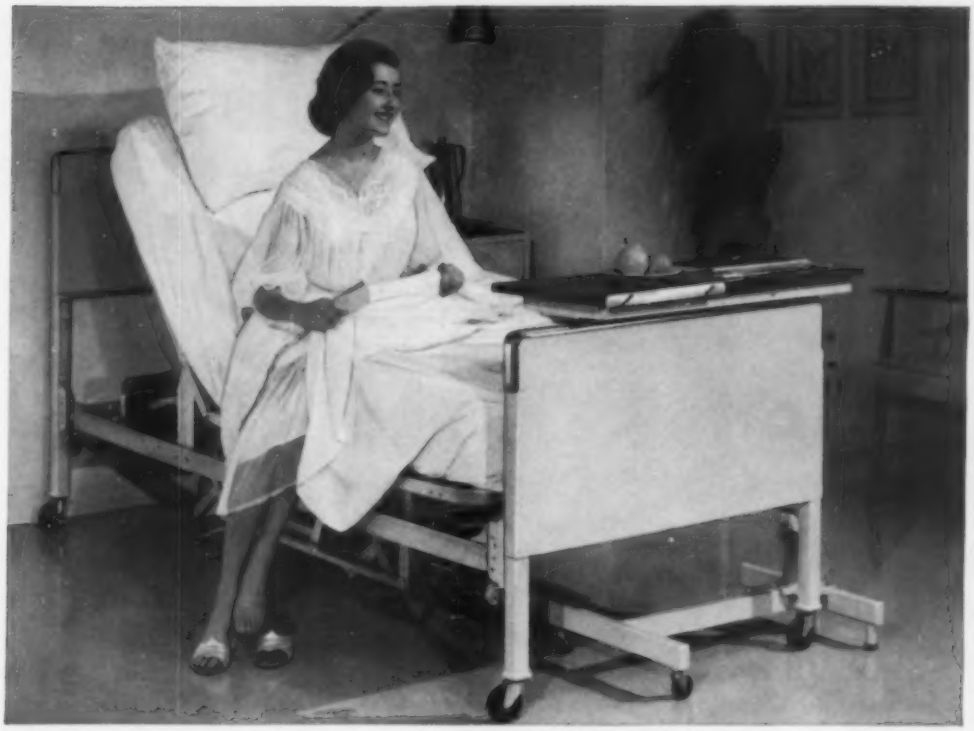
SIM-MATIC

Controlled by push-buttons on hand-held switch. Head and knee sections as well as height are electrically adjusted by low-voltage control. Permits all posture positions that are available with standard 2-crank spring model. Textolite-covered head and foot panels, with stainless steel trim. Built-in brackets for safety sides, sockets for orthopedic equipment.



MOTORIZED BEDS

All Simmons motorized beds are listed by the Underwriters' Laboratories.

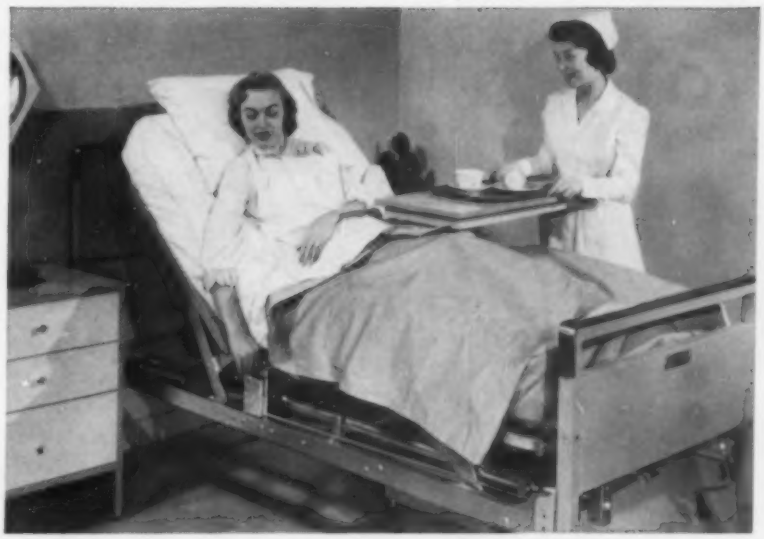


DUAL-HITE

Costs little more than manually operated beds. Utilizes new, simplified principle which changes *spring* height. Hand-held control adjusts bed positions. To get out of bed, patient engages easy-to-reach lever which changes spring movement, lowers foot section as head section is raised. Built-in brackets for safety sides, orthopedic equipment.

MOTORIZED VARI-HITE

Available with or without patient control handle. Double-throw toggle switch at foot end of bed rail operates motor. Takes only 45 seconds to raise or lower from maximum to minimum height safely and surely. Motors may be stopped at any intermediate height. Instantly reversible. Permits quick Trendelenburg or Fowler position.



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"Oh no... not another compress..."

I've got three of them already. "What in the world has happened to progress?" Steady, girl... steady. Maybe it's not too awfully bad. Maybe it needs just a little pad. "Complete leg and thigh? Two of them?" Well, this day is certainly shot—these things should be condemned... I'll surely be if they're not. "Why in the world don't they get something new? You say there is? We have? We do?"

aquamatic K *pad*

The flexible pad laced gently into place, holds in the moisture, restricting evaporation. Constant heat with temperatures always within 1°F. Just check the compress about every few hours. Time saved has been measured at an almost unbelievable 86%. Pads in several sizes. Comfortable. Light in weight, not bulky. Whisper quiet control unit stays on bedside table. For complete information and test data, write: Gorman-Rupp Industries, Inc. or ask your American Hospital Supply Corp. representative.

GORMAN-RUPP INDUSTRIES, INC., BELLVILLE, OHIO

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Start with Royal's unique, 3-position Universal Safety Side. Finger-tip adjustment moves the side **up** for full protection, **down** below mattress for easy housekeeping, **in-between** to provide firm support to patients getting in and out of bed. Here's new security from accidental roll-outs. New freedom for ambulant patients. Only Royal gives you so many different safety sides to choose from. Each is designed to meet specific needs and specific budgets. Royal designs for both patient safety and staff convenience; there's never any interference with medical equipment or over-bed tables. For complete facts, use coupon below. In Canada – Galt, Ontario. SHOWROOMS: New York, Chicago, Los Angeles, San Francisco, Seattle; Galt, Ontario.

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HOSPITAL FURNITURE

Avoid tragic errors!

SCHRADER SAFETY-KEYED MEDICAL GAS OUTLETS MAKE PIPED SERVICES AS AVAILABLE AS ELECTRICITY

SAFETY KEYED
Each service outlet has a separate plug-in adapter that's absolutely non-interchangeable. Color-keyed for each service handled too. Tamper-proof plugs available.

ANY COMBINATION
Single, double or triple outlets are now available. Soon: 4-service outlets. Choose any combination of services.

FLUSH MOUNTED OR EXPOSED
Flush-mount for built-in installations. Exposed units for modernization. Adapters for each service are interchangeable between flush mounted and exposed type outlets.

PRACTICAL
No wheeling of tanks. Plugging in or disconnecting is a one hand operation. Long-lived nylon pawls reduce friction. Stainless steel plates are durable, easily cleaned.

ACCESSORY BRACKET
Holds vacuum bottle, gauge and control valve in true vertical position for reliable operation.

EASY INSTALLATION
Flush outlets are mounted in standard electrical wall boxes. Twelve inch copper, lead-in tubes are silver soldered to check unit bodies, ready for connection.

Be sure you have Schrader Safety-Keyed Gas Outlets in your piped system installation. Write for complete details including illustrated technical literature.

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FIRST NAME IN THE SAFEST
MEDICAL GAS CONTROL OUTLETS

EVERYONE IS HAPPIER WITH FLEET ENEMA

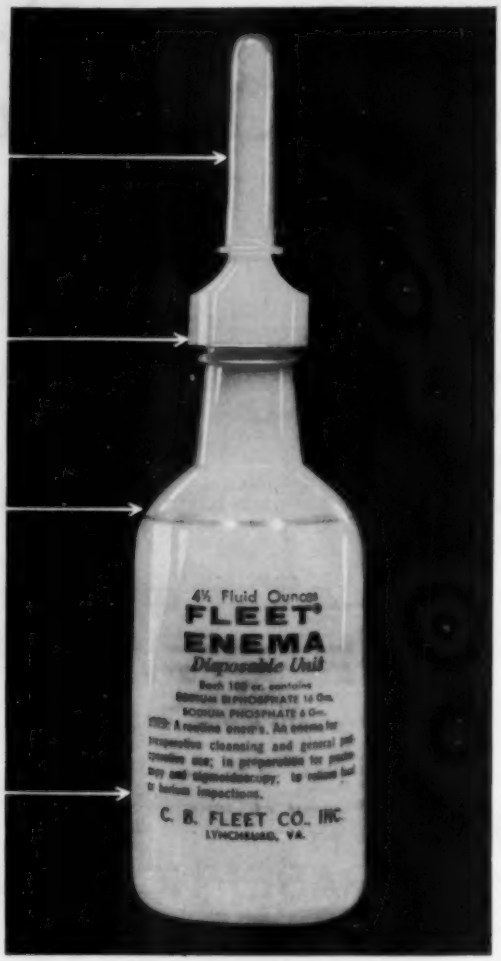
because it's as easy as 1.2.3

Pre-lubricated, anatomically correct 2-inch rectal tube avoids injury

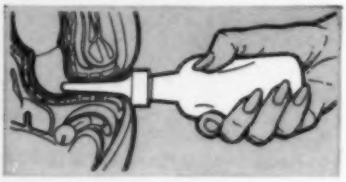
Check valve regulates flow

4½ fl.oz. of precisely formulated solution provides quick, thorough cleansing without patient discomfort

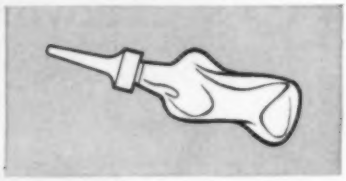
Compact squeeze bottle unit — no loose or moving parts



1. ***Ready to use*** . . . no preparation necessary . . . just remove protective cover



2. ***Easy to administer*** . . . by nurse or patient . . . takes less than a minute . . . just squeeze bottle with one hand



3. ***Disposable*** . . . simply discard unit after use . . . eliminates cleanup and sterilization

FLEET® ENEMA

READY-TO-USE SQUEEZE BOTTLE

C. B. FLEET CO., INC. Lynchburg, Va.

100 cc. contains: 16 Gm. sodium biphosphate and 6 Gm. sodium phosphate in 4½-fl.oz. squeeze bottle. *Pediatric size,* 2¼ fl.oz. *Also available:* Fleet Oil Retention Enema, 4¼-fl.oz. ready-to-use unit containing Mineral Oil U.S.P.

part of our excellent patient care for 17 years"

"The first aim of BAPTIST MEMORIAL HOSPITAL is to give our patients, whose lives we are entrusted with, the finest possible care.

"This is being accomplished by the combined efforts of the 2,000 professional and service people who comprise our staff.

"Aiding this staff is a 23 unit vertical transportation system that dates from our early car switch passenger elevators to today's completely automatic AUTOTRONIC® elevators.

"All are by OTIS.

"And for good reasons: Our original purchase was made with the future in mind. We intended to grow along with Memphis so we decided upon OTIS, a company and equipment that could be depended upon to meet our growing vertical transportation requirements.

"At the same time, we decided that OTIS had highly skilled local maintenance that would keep our elevators running like new.

"And, in addition, should an unpredictable emergency occur, OTIS with its local Memphis office could provide service in a matter of minutes.

"How pleased we have been is best expressed by saying that local OTIS Elevator Maintenance has been part of our excellent patient care for 17 years."

elevator maintenance

Otis

LOCAL SERVICE IS ONLY MINUTES AWAY

SERVICE IN 297 CITIES ACROSS THE UNITED STATES AND CANADA

American's Dyna-Pak® Laundry Press is the.....

fastest!

What head action! In closing, the initial movement, smooth snubbing and full pressure are combined in *one fast, continuous sequence.* Return from pressure through snubbing to full open is just the same. This means production like you've never known.

St. James Hospital, Chicago Heights, Ill., reports their DYNA-PAK Presses are very fast, deliver maximum pressure, and have exceptional heat transfer.

easiest to maintain!

DYNA-PAK is a maintenance engineer's dream! No toggles, cams, levers or pivots to lubricate, adjust or replace. Only three mechanical operating elements (Yoke, Head-Closing Cylinder, Sealed Power Unit), and up to 400 fewer parts than any other laundry press you can buy.

These DYNA-PAK Presses at Henry Heywood Memorial Hospital, Gardner, Mass., are designed with a minimum number of working parts that make maintenance easy and eliminate costly down time.

smoothest!

DYNA-PAK gives the smoothest operation ever. And it's quiet too! No noisy slamming or jarring, no loud, disturbing exhaust. DYNA-PAK is a real pleasure to work on.

This smooth-operating, high-speed DYNA-PAK Press (left) produces an excellent quality finish on all types of work at Latter Day Saints Hospital, Logan, Utah.

most productive!

DYNA-PAK outproduces them all! No other laundry press has such instant response, such smooth, quiet, shock-free action. The high-speed DYNA-PAK helps operators make more money for themselves and for you.

DYNA-PAK Presses get the work out faster, writes St. Mary's Hospital, Grand Rapids, Mich. Also, operators are happy with ease of operation and superior quality of work.

....*fastest!*
smoothest!
easiest to maintain!
most productive!
easiest to use!

easiest to use!

DYNA-PAK'S convenient, finger-touch push buttons instantly initiate the fast, smooth application of high, uniform pressure. No adjustments are ever necessary as hydraulic cylinder of *Sealed Power Unit* and unique "floating" head automatically compensate for different thicknesses of garments and varying conditions of padding on the buck.

At Northside Hospital, Youngstown, Ohio, easy-to-use DYNA-PAK Press (left) enables operator to produce fine-quality work with a minimum of time and effort.

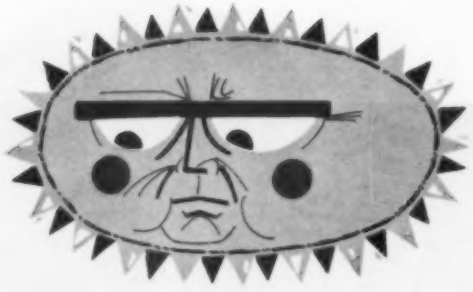
you get more from **American**

AMERICAN LAUNDRY MACHINERY INDUSTRIES CINCINNATI 12, OHIO

AMERICAN LAUNDRY MACHINERY INDUSTRIES ALM-798
CINCINNATI 12, OHIO

Please send me illustrated Catalog AK 230-002 showing various models of DYNA-PAK Presses.

NAME_____
FIRM_____
STREET_____
CITY_____ ZONE_____ STATE_____



WHY RUN OUT OF ICE?

ONLY CARRIER ICEMAKERS HAVE CERTIFIED CAPACITY!

No more guessing!

Now you can have a truly dependable ice supply. Every Carrier ice machine is installed with its capacity certified in writing. There are no "up to" qualifications, no "average production" figures. The actual amount of ice you can expect is determined according to summer temperatures in your area, and backed by Carrier's certificate. Nobody else gives you this protection.

Cubes, crushed, flakes or chips!

There are 16 Carrier ice machines, giving you exactly the kind of ice you need. And besides getting the exclusive advantage of certified capacity, with a Carrier Icemaker you can save as much as 80% on the actual cost of ice. For complete facts and figures, call your Carrier dealer, listed in the Yellow Pages under Ice Making Equipment. Or write Carrier Air Conditioning Company, Syracuse 1, New York.

Carrier

Air Conditioning Company

EXCLUSIVE NEW BUCKEYE METHOD CUTS COST OF MAINTAINING YOUR TERRAZZO FLOORS!

NEW

Buckeye

TERRAZZO SEAL AND FINISH

Easy to apply... dries in 15 to 20 minutes instead of 3 to 4 hours! Won't discolor surfaces!

Dries in only a tiny fraction of the time required by ordinary terrazzo seals. Gives your floors a beautiful high gloss that's safely non-skid—without need for time-consuming buffing. Saves money, too, because it can be patched in the heavy traffic areas without doing over the entire surface. BUCKEYE is safe and odorless—a pure white water emulsion that won't turn yellow. Stubbornly resists the discoloring action of water, soap and food spillage. Surfaces are guarded against dusting, chipping and general disintegration. Seals pores against dirt and grime. PROTECT AND PROLONG THE LIFE OF YOUR TERRAZZO FLOORS WITH BUCKEYE TERRAZZO SEAL AND FINISH.

Also recommended for Asphalt, Composition Tile, Cork, Clay Tile, Quarry Tile, Vinyl, Marble.

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DAVIES-YOUNG SOAP COMPANY
P.O. Box 995, Dayton 1, Ohio

☐ Please have your representative call.
☐ Send me more information.

Name_____

Address_____

City_____ State_____

TERRAZZO SEAL

D.Y QUALITY SINCE 1944

Contact your nearest distributor for information about this and other Buckeye products.

THE DAVIES-YOUNG SOAP COMPANY
P.O. Box 995—Dayton 1, Ohio

Rochester General Hospital—Northside Division, Rochester, N. Y.

Why the Rochester General Hospital chooses Cannon towels

The Rochester General Hospital and other outstanding hospitals from coast to coast count on Cannon for...

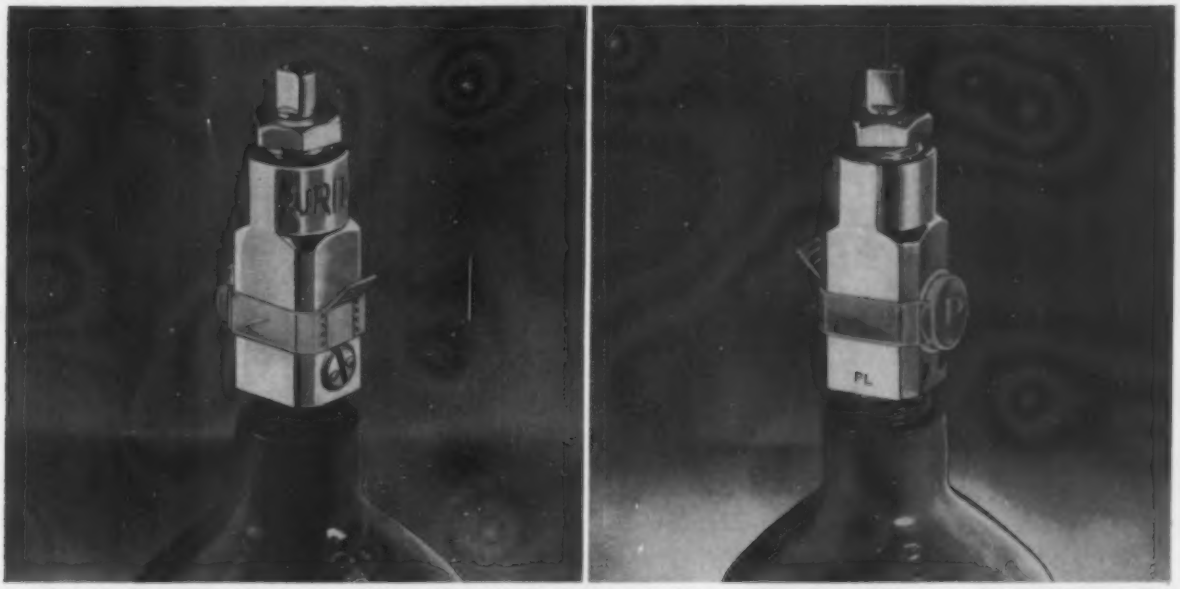
* QUALITY
* VALUE
* SERVICE
* DEPENDABILITY

Also ask your supplier about Cannon's new 180 all-cotton percales.

CANNON

Cannon Mills, Inc., 70 Worth St., New York 13, N.Y.
Towels · Sheets · Name-Woven Towels

PERMANENT SEAL



UNTIL READY FOR USE

NOW . . . a Puritan FIRST in VALVE SEAL Convenience and Purity Protection!

Here is a positive-protection, non-slip valve seal that holds fast until cylinder is ready for use—yet "breaks" easily for removal. Its soft green color is clearly visible for quick recognition of full cylinders in stock.

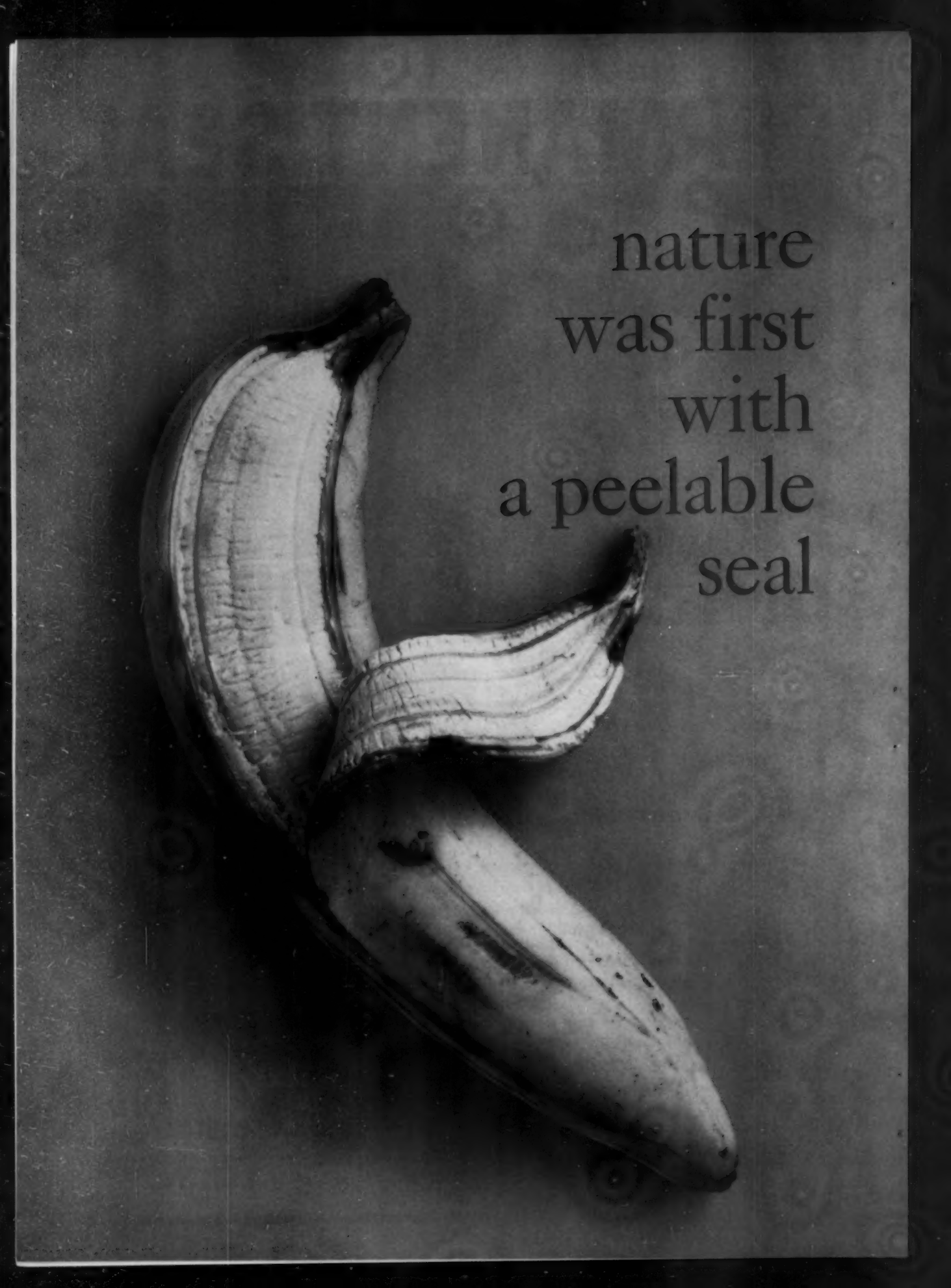
Because it is non-reusable, the new Puritan VALVE SEAL assures both the purity of the contents and a fresh full cylinder.

Ask your Puritan representative to demonstrate the benefits and convenience of this remarkable new VALVE SEAL.

Products and Service for Better Patient Care

Puritan
COMPRESSED GAS CORPORATION
SINCE 1913
KANSAS CITY 8, MO.

For additional information, use postcard facing back cover.


nature
was first
with
a peelable
seal

Johnson & Johnson

was first to provide sterile dressings in peelable seal packages.

This unique packaging technique permits easy removal without contamination of the contents. Once opened it cannot be accidentally resealed. The user may be certain that "a sealed package is a sterile package."

Specify the most trusted name in sterile dressings for hospital use.

SMALL HOSPITAL QUESTIONS

ANY QUESTIONS?

The Modern Hospital will be glad to try to answer them.

If you have a problem or if you're just curious about a procedure or a statistic, please feel free to write this department, care of The Modern Hospital, 1050 Merchandise Mart, Chicago 54.

Standards Committee Suggested To Control Equipment

Question: In the near future our hospital hopes to establish a standards committee to act in conjunction with the purchasing department. In addition to this, we also hope to develop the necessary systems and procedures for control of our capital equipment; the latter to be useful for purchasing, maintenance and accounting department purposes. Could you suggest references to information on either or both of these subjects?

Relative to the equipment inventory control, we would like to have such information as who usually keeps this kind of record. Specifically, what types of information are recorded? Is the record kept in one central location, or are copies distributed to various interested departments? Is it necessary to tag equipment upon receipt and what control is exerted over the transfer of equipment from one department to another? — I.J., N.Y.

ANSWER: From a purchasing department point of view the standards committee is the most important committee in the hospital. This committee should consist of the purchasing agent as chairman, the head storekeeper, director of nurses, assistant director or director of the hospital, the operating room supervisor, chief pharmacist, chief surgeon, and any other person within the institution that you think may be helpful to the committee.

The committee has as its objectives the following:

1. To simplify and standardize all materials, supplies and equipment used within the institution.
2. To avoid the acceptance of products produced by unreliable manufacturers.
3. To assist in the establishment of standard specifications for materials, supplies and equipment.
4. To aid in selecting the requisite quality of products to fit the purpose for which an item is to be used.
5. To review and approve or disapprove recommendations for the deletion of or addition to the standards adopted for the institution.

In answer to the second part of your inquiry, we never felt that it was worth the time and effort to tag equipment upon receipt or to exert any control over the transfer of equipment from one department to another.

When I came to the Cleveland Clinic 10 years ago we did institute a system of keeping an equipment card for every new piece purchased. This record is kept in the purchasing department on a 3 by 5 inch index card and alphabetized according to type of equipment. A sample of the card is shown below at left and you will see that it gives a ready reference when we wish to know the quantity and types of typewriters, adding machines, or automatic analyzers that were purchased during the last 10 years.—PAUL E. WIDMAN, *director of purchasing, Cleveland Clinics, Cleveland.*

F 317 CLEVELAND CLINIC
Equipment Purchase Record

Serial No. _____

Article _____

Description _____

_____

Order No. _____ Cost _____

Purchased from _____ Date _____

Located in _____ Department

Cards like one shown here are used to record purchases of equipment. Back of card provides space to record date, order number, and cost of repairs.

Must Cultures Be Routine?

Question: Our infections committee has requested that we do throat cultures on all personnel of the pediatric, obstetrical and surgical departments. Is this considered necessary? I have found that other hospitals are not taking routine cultures, but only doing them when indicated. — Sr. R., Canada.

ANSWER: This query was referred to one of our consultants who replied as follows:

"The taking of routine cultures is not normally done by hospitals, but is usually done when there is some reason to suspect that a staphylococcus infection of the throats of personnel is responsible for infections of the wounds of patients.

"Certainly, if the infection rate among patients in the hospital is high, the cultures should be taken in order to locate the sources of the infection, but there is more to it than the mere taking of throat cultures.

"Cutaneous infections must be searched for, and infections of the vulva and perineal regions must be suspected in females. This is particularly true where the hospital has student nurses, and in this regard some hospitals set up clinics for the examination of the student nurses. Some people even recommend taking cultures of the sheets and pillowcases of the student nurses' beds in order to determine the sources of hidden infection in these girls."

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YOU
CAN
AFFORD...

...THE
MOST
MODERN

AUDIO-VISUAL TRANSISTORIZED *NURSES CALL SYSTEM*

Now *voice communication* is within your budget because Couch has simplified the wiring to save you major installation expense.

A twisted pair is all the additional wiring you need to convert a visual nurses call system to the new Couch audio-visual system. You save money by using existing wiring.

For new installations, this Couch system requires *less labor* and *fewer wires* than any other comparable system.

Another important saving: no expensive shielded wire is required.

Call on your Couch sales engineer for a demonstration *right in your own office — at your convenience.* Or write for full details to:

S. H. Couch 1894 COMPANY, INC.

3 ARLINGTON STREET, NORTH QUINCY 71, MASSACHUSETTS

NURSES CALL SYSTEMS • STAFF IN AND OUT REGISTER SYSTEMS • STAFF VISUAL PAGING SYSTEMS
MODULAR FIRE ALARM SYSTEMS • PRIVATE TELEPHONE SYSTEMS

If there is ever a better flush valve . . . its name will be SLOAN

1951

1961

You can't always SEE product improvements

At first glance, the latest Sloan ROYAL Flush Valve looks much like its predecessor. Same gleaming nickel-chrome finish, same expert workmanship, same smart appearance. But if you could see inside, where flush valve performance counts, you would find product improvements that make the 1961 ROYAL the standard by which all other flush valves are judged.

Product improvement that is more than just "skin deep" has been the keynote to Sloan leadership for over half a century. Sloan strives constantly to build its flush valves even better, adopting changes only after thorough experimentation and field testing.

Here are a few of the engineering firsts that continue to sustain Sloan leadership: no regulation; non-hold-open; segment diaphragm; inside cover; and use of Du Pont Delrin® for some parts.

These, and other features, are the bonus of quality you expect with the ROYAL—the finest flush valve ever made.

SLOAN FLUSH VALVES

SLOAN VALVE COMPANY • 4300 WEST LAKE STREET • CHICAGO 24, ILLINOIS

wire from Washington

KEFAUVER BILL HEARINGS TO START

With all other health and medical legislation dormant for the time, interest centers on the proposals of Sen. Estes Kefauver (D.-Tenn.) to put further restrictions on the pharmaceutical manufacturing industry and at the same time to simplify the problems of hospital formularies. This time Senator Kefauver—chairman of the subcommittee that for almost two years has been investigating the prescription drug industry — is not standing alone. President Kennedy has indicated an active interest in the argument over price of drugs, and Robert Kennedy, the attorney general, has said the Department of Justice will look into possible industry violation of antitrust laws.

Hearings may start as early as mid-May on the Kefauver bill, which was introduced in the House by Chairman Emanuel Celler (D.-N.Y.) of the judiciary committee.

On introduction of the bill, Senator Kefauver won a dispute with Chairman Lister Hill (D.-Ala.) of the Senate labor and public welfare committee. Because Senator Kefauver drafted his bill to put emphasis on antitrust and patent problems in the drug industry, it was assigned to the judiciary committee, and will be passed on to Senator Kefauver's subcommittee. Normally, legislation of this type — most of the provisions are concerned with amendment of Food and Drug Administration laws — would be assigned to Senator Hill. The committee choice was a disappointment to the drug industry, which feels that Senator Kefauver has demonstrated his prejudices in the drug hearings, while Senator Hill is regarded as open-minded.

There is the possibility that Senator Kefauver will start out with hearings on the antitrust and patent phases of his legislation, then arrange joint hearings with Senator Hill's committee, or at least work in close collaboration with it.

Of particular concern to hospitals are these provisions of the Kefauver-Celler bill:

1. Food and Drug Administration would have the responsibility for establishing the official or generic names for drugs.

It is Senator Kefauver's opinion that this would promote hospital formularies and be of service to individual physicians who prefer to use generic names. He believes that with the F.D.A. in charge, the result would be "simplification of generic names which, in contrast to the short and simple trade names, are often so long, complex and unpronounceable that they cannot possibly be remembered or used by physicians." Obviously, if the generic names were made simpler hospitals would have less difficulty in convincing physicians to make more use of the formulary, thus in many cases saving money for the patient or the hospital.

Also, Senator Kefauver would attempt to reduce the number of patentable drugs, another move that would simplify the operations of a formulary.

His bill would rule out patents for new drugs that are merely combinations of two or more drugs already in existence, "whether patented or not," and for drugs that are merely molecular or other modifications of existing drugs. The only exception would be if the Secretary of Health, Education and Welfare determines that the new drug's therapeutic effects represent a significant improvement.

2. Two changes are proposed to keep doctors better informed of drug advantages and liabilities, and presumably thus more inclined to prescribe from formularies. Manufacturers would be required to provide physicians with "clearer, better and additional information on the bad as well as the good features of drugs."

Information mailed by the manufacturers to the doctors would have to include "a true copy of all printed matter which the Secretary of H.E.W. requires to be included in the package in which the drug is sold."

On this point Senator Kefauver comments: "It is only common sense that the printed matter in the package [sent to the druggists], which may and frequently does contain essential cautionary information which is not shown in advertising material sent to doctors, be automatically furnished to doctors in convenient form."

A second effort to keep doctors better informed about drugs would be the requirement that the H.E.W. Secretary annually would mail to all physicians the complete brochure information on dangerous drugs. (Presumably H.E.W. could delegate this responsibility to an official or quasi-official organization.)

3. One provision is designed to give doctors assurance they can prescribe any drug in the knowledge that it is as safe, potent and efficacious as represented by the manufacturer. This is the authorization for F.D.A. to make complete inspection of drug plants, including access to complaint files and personnel files, the latter to ensure that employes are properly trained for their assigned tasks.

The factories would be licensed, and the applicant would have to demonstrate to H.E.W. that his plant "meets such standards as the secretary shall determine necessary to ensure the continued chemical structure, strength, quality, purity, safety and efficacy of the drug." The H.E.W. Secretary could revoke the license if the plant fell below standards.

On this, Senator Kefauver said: "The large companies have been quite successful in their campaign for making well advertised brand names synonymous with high quality," and as a result doctors prescribe the heavily promoted names and are reluctant to prescribe by generic

names. He thinks that these changes would give the doctor assurance that *any* manufacturer's product is as good as any other, and thus encourage him to prescribe the cheapest drug.

4. A requirement for mandatory licensing of patented drugs is Senator Kefauver's chief machinery for beating down prices.

His bill would allow the patent holder to produce the drug exclusively and sell it at his own price for three years after issue of the patent. All "qualified manufacturers" would have access to the patented drug at that time, with the royalty to be no greater than 8 per cent.

The Senator has this justification for the proposed patent liberalization: "Alone among the industrialized nations of the world, we grant product patents on drugs with no provision for compulsory licensing or any other protection to the public interest. Since drugs are vital to the health of the nation, we must recognize that some limitations on patent monopolies are justified by the captive position of the users and the relationship of drugs to public health."

Senator Kefauver's other recommendations are changes in the antitrust laws to prevent collusion over issue of drug patents and the award of licenses, and a requirement that F.D.A. be entrusted with determining the efficacy as well as the safety of all drugs.

Obviously Senator Kefauver will not get all he is reaching for – but he will get something, either this year or next. The drug industry – joined by American industry in general – will fight to the end to avoid compulsory licensing. Also, it already has been pointed out that the big, reputable, highly successful companies would have less concern over complete factory inspection and factory licensing than the small operators who are able to sell at cut prices.

It is a reasonable expectation that Senator Kefauver will win Congress over to two changes that would be of the greatest importance to hospital formularies: A faster, simpler system of determining generic names, and a mandatory, centralized system for getting drug information into the hands of doctors.

The same week the Kefauver-Celler bills were introduced, Senator Kefauver's subcommittee released its annual activities report. The drug section is not much more than a rerun of the squabbles between Democrats and Republicans that marked the progress of the hearings.

AGED CARE STAYS ON STAGE

While there is no indication of congressional action on President Kennedy's plan for old age medical care under social security, the issue continues to be aired nationally.

One trend is the obvious effort of Administration leaders to pin-point American Medical Association as the backbone of resistance to the idea, ignoring for the most part American Hospital Association, American Dental Association, the U.S. Chamber of Commerce, and the insurance interests, which also oppose the idea.

NOTES

In a civil defense demonstration staged in Congress' backyard, a skilled team of workers set up a complete C.D. hospital unit with operating room and x-ray equipment in one hour and 40 minutes. The unit is the standardized C.D. packaged hospital, packed in 351 cases containing 8000 individual pieces of equipment, including x-ray equipment that can turn out a print in 60 seconds. Sixty naval reservists, Boy Scouts, C.D. personnel, and Red Cross workers handled the task.

Legislation to continue the practical nurse training program for another four years has passed Congress and awaits the President's signature. The matching grant operation calls for $5 million in U.S. funds annually.

Appearing before Senator Hill's appropriations subcommittee, H.E.W. Secretary Ribicoff urged that Hill-Burton hospital construction funds be held at the same level as this year – $186 million.

An indication of the slow pace of health legislation this year: American Hospital Association has had only one official witness on Capitol Hill. He was Dr. Karl S. Klicka, executive director of the Hospital Planning Council for Metropolitan Chicago, who asked a Senate subcommittee to give hospitals the same opportunity as other nonprofit organizations to buy land in urban redevelopment areas. Under these conditions land is sold for the cost of clearing it.

At this writing, it appears hospitals will continue to be exempt from requirements of the new minimum wage bill that shortly will clear Congress.

Of a number of Veterans Administration hospital bills under active consideration in the House, the one most likely to be enacted calls for pay raises for hospital managers. Under present practice, many senior specialists earn substantially more money than hospital managers.

Time lag between new research developments and their application means the following preventable deaths each year: 40,000 from cancer, 20,000 from rheumatic fever and rheumatic heart disease, plus 60,000 needless cases of tuberculosis. Details are presented in a new P.H.S. publication, "The Costly Time Lag."

The Atomic Energy Commission on July 1 ends its program of giving discounts on radioisotopes for domestic medical research, "consonant with the commission's policy of withdrawing from the supply of services or materials as commercial sources establish the ability to assume such responsibilities."

Hepatitis Vaccine Tests Under Way

CHICAGO.–Tests of a new vaccine that may prevent infectious hepatitis have been going on for five years at the state penitentiary at Joliet, Ill., according to an exclusive report in the *Chicago Daily Tribune*.

The tests on 200 convict volunteers were directed by Dr. Joseph D. Boggs, director of laboratories at Children's Memorial Hospital here and an associate professor of pathology at Northwestern University Medical School, the newspaper disclosed.

Although Dr. Boggs declined comment, the *Tribune* said it had learned the tests:

1. Confirm isolation of the infectious hepatitis virus first announced in 1955 by investigators of Parke, Davis & Company.

2. Demonstrate that immunity can be established to prevent the disease, to which humans are alone susceptible.

(For a round-up of information on hepatitis, see page 69.)

The Modern Hospital
MAY 1961

LOOKING AROUND

Only Place

IF ANYBODY needed proof, it was plain at the recent meeting of the National League for Nursing (see page 80) that hospital nursing schools are still being kicked in the shins by some of the nursing organization officials who keep insisting that they *love* hospital nursing schools. This has been going on for some years now, and hospital people will examine the evidence again later this year and decide whether they want to keep on rubbing their shins or kick back.

Whoever is holding the clipboard, it seems likely that some changes in nursing schools may be needed — though not necessarily the ones that have been called for. The way things have developed on nursing floors, the need is for a lot of medical technicians who can do injections and dressings, and worse, and keep the doctors happy, and a lot of bodies to pat pillows and wrestle bedpans and keep the patients happy, and a few executive geniuses to keep the technicians and pillow patters out of each other's hair, and off each other's toes, and keep the administrator happy — or at least asuicidal.

Possibly it is true, as some nurse educators have charged, that the three-year hospital school is not in step with today's needs, but if this is indeed the case, the thing that should be changed first is the length of the course and not the location of the school. The technician may need more than three years' training and the pillow patter less, but their tasks must all be learned in the hospital, because that is the only place they are performed. It is unlikely that the kind of talent it takes to run a nursing floor can be discovered anywhere else, or taught anywhere.

Under anybody's jurisdiction, what the hospital schools need most is freedom to experiment with new programs, not restriction to old standards.

Called-Off Conference

HOSPITAL architects are fond of saying that theirs is the most difficult of all design tasks. Nowhere else in industry are so many complex, interrelated functions brought together, they point out; nowhere else does change come so rapidly, nor with such dramatic impact on the need for facilities and services. Nowhere else are there so many *kinds* of standards. A Mayo-trained surgeon wants his operating and scrub and utility spaces arranged as they were at Rochester; a Cornell man favors the New York Hospital plan; the Massachusetts General nurse will never like the unit that was laid out to suit the Columbia graduate.

"Nobody can argue against the *theory* of including doctors, nurses and other responsible department heads in planning conferences," an architect who is a practiced hand at hospital design remarked not long ago. "But the architect, the administrator and even the building committee can easily get caught in the middle when staff members representing different disciplines disagree." At best, time is wasted and heads are bumped under these circumstances, the architect said; at worst, differences are settled by compromise solutions that don't work very well for anybody.

Instead of horizontal planning parleys, our man recommends *written* statements of need by the various medical and other departmental interests, then *unilateral* conferences with the architect and administrator — and decisions by them: "If they know their business, their solutions will work. If they don't, they should have a consultant who does. Either way, they don't need a surgeon or pharmacist or nurse telling them how the doors should be hung."

This procedure may violate textbook doctrine on democratic administration, but it cuts down change orders. The only trouble with discussing differences around a table is that it doesn't always work. Sometimes, the better we understand the other party's position, the worse it looks. Successful administration depends heavily on knowing when group discussion is likely to produce results and when it is likely to produce only hoarseness.

Equilibrium

SPEAKERS, writers and thinkers on the hospital scene are fond of referring in loving accents to "the American hospital system" or "our voluntary hospital system." More often than not, the context links the hospital system with the private practice of medicine and, by implication if not in so many words, sets it apart from, and superior to, the government systems of hospital and medical care that prevail in other countries.

Actually, our voluntary hospital system isn't a system at all. The principal characteristic of a system is that it is ordered or organized; the parts are coordinated so as to improve the productivity or excellence of the whole. A system has unity of purpose, method and result. In the hospital field we have systems in the armed forces and the Veterans Administra-

tion; the states have their systems of tuberculosis and psychiatric hospitals. The vast remainder of American hospitals—all the city, county and district hospitals; the church and fraternal hospitals, and the hospital corporations, profit and nonprofit—all these are plainly unordered, unorganized and uncoordinated, one with another, with little unity of purpose, method and result. Since it has a settled existence this might be referred to as the hospital establishment; certainly it is no system.

However ordered or unordered, why do we call this establishment "voluntary"? There is little that is really voluntary, for example, about our city, county and district hospitals. These are built and supported for the most part out of funds contributed by taxpayers whose only freedom of choice if they don't want to pay the taxes is to move and pay them somewhere else. Church and fraternal and corporation hospitals are voluntary to the extent that they are built and supported by funds contributed by persons acting with complete freedom of choice. Nearly all the current income of these hospitals, however, comes from patients paying their own way, by one method or another. These patients, to be sure, are mostly free to choose their own doctors, who then choose hospitals for them, so there is this much more that might be considered voluntary about these hospitals. Actually, the term is descriptive of an institution that has largely vanished—the great charitable hospital supported wholly by freely given philanthropic funds. For the most part, these institutions have become businesses today; much as they still depend on philanthropy, they depend even more on patient income and, in some cases, tax support. Their voluntariness has thus been diminished in fact. What has not been diminished, and what we really mean when we refer to a voluntary hospital system that is largely involuntary and wholly systemless, is the voluntary spirit—the devotion to cause that keeps men and women working in hospitals when they are free to choose less exacting assignments, the dedication to purpose that keeps hospital trustees and auxiliary members accepting burdensome responsibilities and performing trying tasks when they are free to exercise their good will without stress in Boy Scout work and parent-teacher associations.

It is arguable, if not indisputable, that devotion and dedication languish when local autonomy gives way to centralized authority and individual initiative yields to group decision—processes which occur inevitably as system is introduced. Thus system opposes the voluntary spirit. The difficult task for hospital planners and thinkers in the future will be to reduce the waste that is inherent in systemlessness without sacrificing the sense of mission that is the essence of voluntariness. The most successful equilibrium will be achieved only if the contradiction of forces is clearly understood.

Differences

WHEN it was first suggested, years ago, that hospitals should consider adopting some of the concepts and methods of industry, most hospital people were aghast. "But hospitals are not like business!" they cried. "Business methods wouldn't work in a hospital!"

In spite of these protests, some hospitals recklessly went ahead and began using modern business methods of accounting and billing, credit and collections, purchasing and inventory—and of course in all these procedures business methods worked very well indeed, and hospital practice was greatly improved, and today hospitals uniformly use these business systems. The handwritten hospital bill is as obsolete as the mustard plaster.

When it was first suggested, some years ago, that industrial personnel methods might be used in hospitals, many hospital people recoiled in horror. "But you can't do that!" they exclaimed. "Hospitals just aren't like industry!"

Nevertheless, some bold or foolhardy hospital people went ahead. They stopped housing and feeding and clothing their employes and paid them in cash instead. They analyzed and classified jobs and established wage and salary administration systems. They studied industry's employment and training methods and adopted industry's vacation and sick leave and other benefit practices. And of course in all these ways industry's methods are working very well, in more and more hospitals. Grievance procedures adopted from industry are now being installed in many hospitals; a few hospitals have even come to terms with unions — and the sun still rises in the East.

When it was first suggested, a few years ago, that some hospital procedures might be systematized or mechanized to advantage, as industry's are, most hospital people shuddered quietly, as one does in the presence of unspeakable vulgarity. "But hospitals are a personal service, and you can't mechanize personal service!" they said. "Hospitals aren't like industry."

But some simple-minded hospital people started fooling around with time and motion studies in the kitchen and housekeeping departments, and even on nursing floors. Work flow studies began to replace the surgeon's crotchet as a method of planning and organizing operating rooms and nursing units and central service departments. Now work simplification is as familiar to the nursery as it is to the factory; the nurse on the floor pushes a button or twists a dial as often as she takes a trip; vital signs are measured electronically in the operating and recovery rooms, and queuing theory, rather than elaborate guesswork, has been used to determine the arrangement of diagnostic facilities and services. Nobody faints any more when the words "automation" and "hospital" appear in the same sentence.

Not long ago, a man who has been involved in planning and equipping the "white rooms" where industry performs some of the more delicate operations in the construction of space capsules suggested to a hospital friend that some of the same technics, involving rigid control of traffic, personnel and air flow through a series of progressively cleaner and cleaner areas to the "super clean white room," might be useful in hospitals.

We wouldn't presume to say whether hospitals can or cannot use this particular industrial technic, or any other. But we do suggest that one difference between the hospital and industry is that the hospital's ownership and purpose oblige it to consider every proposal for improvement in method, from whatever source, whereas industry is at liberty to make its own choices. The difference between industry and hospitals will be honored most effectively when hospital people stop emphasizing the differences and start considering the similarities.

What Hospitals Should Know About HEPATITIS

Medical and public health authorities warn hospitals that viral hepatitis is a problem for them and suggest measures that will help to prevent the problem from becoming a threat

Jane Barton

WHILE infections committees are concentrating their energies on combating and controlling the spread of staphylococcal infections, another enemy may be quietly infiltrating hospitals through unguarded entrances.

The enemy is viral hepatitis (inflammation of the liver), which is now recognized as one of the most serious communicable disease problems in the United States. According to public health and medical authorities, it is also a serious hospital problem, with legal complications.

Viral hepatitis is tricky, elusive and dangerous. Furthermore, it seems to be twins — a circumstance that has caused immeasurable confusion and debate among the clinicians, public health officials, and research workers who have had to wrestle with it.

Asked whether hepatitis is really a single entity or a group of viruses, Dr. Alexander D. Langmuir, chief of the Epidemiology Branch of the Public Health Service's Communicable Disease Center in Atlanta, explained it is now generally accepted that there are two types of hepatitis: infectious (designated Virus A) and serum (Virus B). "The incidence of infectious hepatitis fluctuates in an orderly seasonal pattern and in a long-term, seven to eight year cycle," he said. "It constitues a high proportion of the total reported cases of hepatitis. Serum hepatitis is different. This disease occurs at a steady rate without much seasonal fluctuation; it causes most of the deaths that are ascribed to hepatitis."

Like staphylococcus, hepatitis has been around for a long time and has been well, if not favorably, known to epidemiologists as the cause of widespread outbreaks in this country for more than a century.[1,2] It was not until 1952, however, that hepatitis was made a nationally reportable disease and only in the past several months that it has made such headlines as "Jersey Watches 400 as Hepatitis Kills 14"; "Hepatitis Strikes 34 Students — City Closes Academy's Kitchens," and "Nation Hit by Record Hepatitis Outbreak."

The last headline, published in a medical news magazine, is borne out by Public Health Service figures showing that cases reported during the first three months of 1961 were 23,161 compared with 9793 in the same period of 1960. The record, 50,000 cases, was established in 1954, and it is expected that the 1960-61 outbreak will exceed this figure. In view of the fact that the number of cases reported to the Public Health Service is only a small part of those that actually exist (in many instances because they have not been detected) it is obvious that the problem is a big one, and getting bigger.

During World War II, the armed forces were made painfully aware of the trouble-making propensities of hepatitis and of its dual nature. Hepatitis hospitalized thousands of servicemen whose

Virus A and Virus B Are Similar Clinically But Differ in Many Ways

services could not well be spared, and in 1942 extensive outbreaks of the disease were traced to batches of yellow fever vaccine buffered with human serum. These events first clearly established the fact that serum hepatitis was a distinct entity. Later in the war period, a great upsurge in cases of serum hepatitis occurred concomitantly with the increased use of blood and plasma. It became dismally apparent that life-giving blood and blood products could lead to serious illness and even become death-dealing weapons.

Serum hepatitis just doesn't behave the way infectious hepatitis does in many respects, although their clinical manifestations are so similar that, as one authority has written, "even now, because of the marked clinical similarity of individual cases of the various viral hepatides, the investigator often must depend entirely on epidemiological data for differentiation."[3]

The differences are to be found basically in the epidemiological and immunological aspects (see accompanying table on opposite page).

The incubation period of Virus A is considerably shorter than that of Virus B, ranging from 10 to 50 days, against 60 to 160 days for Virus B.

Virus A is primarily a disease of children and the teen-age period and spreads by contact in schools and within families. It is carried in both the feces and the blood. Like the polio virus, it is transmitted by the fecal-oral route from person to person; it is also transmitted by parenteral injections.

Virus B (serum), on the other hand, is found only in the blood. Understandably, it is primarily a disease of adults since it is transmitted by blood transfusions and other parenteral injections which are more likely to be given to adults than to children.

The course and severity of hepatitis vary widely according to the age of the patient. Virus A is usually milder in children than it is when it attacks adults. The lowest death rates are found in this age group. "Mortality rates increase with age," Public Health Service officials report, "suggesting the possibility of either an increased severity of infectious hepatitis in older individuals or an increased frequency of serum hepatitis in the older age groups."[3]

One of the trickiest features of the disease is that while jaundice is the classical symptom, in milder cases the patient may show no evidence of it whatever. So anicteric (nonjaundice) hepatitis may go unrecognized.

Tests on human volunteers have shown that the Virus A and Virus B organisms are distinct entities immunologically.

There is no known immunizing agent against Virus B, whereas gamma globulin (or immune globulin), a fraction of the blood, is highly successful in protecting persons who have been exposed to Virus A – if it is given early enough in the incubation period. The effects of immune globulin are not felt until after six to 10 days, Dr. James O. Mason, chief of the surveillance section of the Communicable Disease Center, explained. He added, "If you're going to come down with infectious hepatitis within six days, you're going to get it anyway. When gamma globulin is given that late in the incubation period, it won't help, though it works very well if it's given early enough." Immune globulin is strictly preventive in its action; it is not beneficial as treatment.

Dr. C. A. Smith (left) is chief of the Public Health Service's Communicable Disease Center, Atlanta, Ga., and Dr. Alexander D. Langmuir is chief of the Epidemiology Branch. The C.D.C.'s major function is to assist state and local health agencies and share its experience with those who seek aid.

Although there is general agreement on the usefulness of immune globulin as a protection against Virus A, there is some controversy about the amount that should be used. A dosage of 0.01 ml. per pound of body weight has been accepted for several years as giving adequate protection and "there has been little evidence of failure," according to Communicable Disease Center officials. Recently, however, Dr. Saul Krugman and his associates at New York University School of Medicine published a study in which they recommended a dosage of 0.06 ml. per pound.[4]

Still another difference between Virus A and Virus B is that while the mortality rate from the former "approaches zero" (less than 0.2 per cent), rates as high as 20 per cent and over have been observed in some outbreaks of Virus B.[2]

Why Is Hepatitis Increasing?

The question that is currently vexing the health field is: "Why the tremendous upsurge of hepatitis cases right now?"

Is it because more cases are being diagnosed correctly? Is it because physicians and hospitals are doing a better job of reporting? (Public health officials would like to think so but they don't really believe it.) Is it because there are actually more cases of hepatitis? If so, why? And where are they coming from?

If no one is able to give positive answers to these questions – and no one seems to be – various medical authorities at least entertain strong suspicions.

One of these is Dr. Richard B. Capps of Chicago, who has contributed many studies to the literature on hepatitis. Dr. Capps stated that "this year [1960-61] has shown a real increase in the number of cases." Although the cyclical pattern of Virus

A has been well established and it could be anticipated that this season would be one of the peaks, Dr. Capps and other authorities observe, the number of cases is too high to be explained entirely on this basis.

Dr. Capps suggests that the fact that Virus B is known to cross the placental barrier (which Virus A does not) could be a contributing factor. In an article published some years ago in The Modern Hospital, Dr. Capps wrote: "Probably the most important factor [in the transmission of hepatitis] is the existence in the population of many apparently healthy individuals who carry the virus in their blood and who at present cannot be recognized. These individuals serve as a reservoir of the virus and as a focus for new cases."

Dr. R. B. Capps

He has not changed his ideas since he wrote the article, and points out that "if being a carrier is a life-time state, you can see how hepatitis could spread like wildfire if mothers are transmitting it to their infants."

When the viruses are finally isolated, many of these questions will be answered and the fog of confusion in which hepatitis has cozily wrapped itself for so long will be dispelled. That day should not be too long in coming. Investigators are even now within whistling distance of being able to state categorically that they have pinned down the organism.

As long ago as 1954, according to a report in the March 11 issue of *Business Week*, the laboratories of Parke, Davis & Co., in Detroit, began testing the blood of hepatitis victims for any unusual or suspicious agents.

"In 1956," the report continued, "one particular agent was found to be common to 90 per cent of patients diagnosed as suffering from the disease. The catch was that the same agent appeared in the blood of from 10 to 15 per cent of ostensibly healthy people. Since then, Parke, Davis has concentrated on cultivating outside the body the agent suspected of being the cause of at least one form of hepatitis — and growing it in sufficient concentration to make a test vaccine."

In a paper presented April 10 at a meeting of the Federation of American Societies for Experimental Biology, Drs. J. P. O'Malley and H. M. Meyer Jr., of the National Institutes of Health, reported on the isolation by Dr. O'Malley of an agent that may be related to serum hepatitis. This agent, referred to as A-1, was recovered on one occasion in rabbit kidney tissue cultures inoculated with material from an icterogenic pool of human plasma known to induce homologous serum jaundice in volunteers, it was explained. It was emphasized that the work done thus far is only *in vitro* evidence and has not been

Although the hepatitis viruses A and B resemble each other closely in many ways, they differ markedly in others. These observed differences include the route of transmission, incubation period, and the method of immunization.

	Virus A	Virus B
1. Route of infection	Both oral and parenteral	Parenteral only
2. Virus demonstrated in	Blood and feces	Blood only
3. Incubation period	10 to 50 days	60 to 160 days
4. Usual type of onset	Abrupt; febrile, often a chill	Insidious; afebrile, or temperature less than 100 F., rarely a chill
5. Abnormal hepatic tests other than serum enzyme levels	Preceded by symptoms for several days	Often precede symptoms by several days
6. Flocculation tests	Usually abnormal	Frequently negative or weakly positive
7. Prevention by prophylactic injections of immune globulin	Yes	No
8. Immunity after infection:		
(a) With virus A	Yes	No
(b) With virus B	No	Yes

Reprinted by permission from: Eichenwald, Heinz F., and Moseley, James W.: Viral Hepatitis—Clinical and Public Health Aspects, Public Health Service Pamphlet 435, Communicable Disease Center, Atlanta, Ga., 1959.

subjected to any clinical assessment. However, the authors were willing to state some "cautious conclusions," as follows:

"An agent has been recovered on one occasion from the 1951 N.I.H. icterogenic pool. This agent produces cytopathogenic effects in a wide variety of cell cultures, but induces no overt disease in common laboratory animals. Serological testing has failed to show any relation between the A-1 agent and a number of recognized viruses. Volunteers infected with serum hepatitis virus from several different sources have, with a high degree of consistency, developed antibodies against the A-1 agent during convalescence. This neutralizing antibody does not occur frequently in the sera of normal animals, including man. However, some selected groups of patients have shown a low or a high incidence of this antibody."

Whether Virus A and Virus B are one and the same, and whether the investigators' hopes that they have actually isolated the cause of hepatitis are borne out by clinical trials, probably won't be proved for a long time.

Even though identification of the virus cannot be considered settled, however, and the difficulties of making positive diagnoses continue to haunt physicians, so many facts have emerged from the studies of investigators that hospitals cannot claim ignorance if they fail to take precautions against both Virus A and Virus B. Furthermore, while controversy continues unabated on virtually every other aspect of viral hepatitis, on one subject at least there is complete accord among medical and public health authorities:

Hospitals can take many relatively simple measures to protect patients and staff against hepatitis in both its forms, and if they don't, they are laying themselves wide open to charges of negligence, particularly in regard to the transmission of serum hepatitis.

What To Do About It

Infectious Hepatitis. Precautions against spreading infectious hepatitis (Virus A) by the fecal-oral route are not yet definable other than maintaining good technics, enforcement of the rules regarding handwashing, strict bedpan isolation, and keeping all known cases together, Public Health Service officials say. Dr. Mason reported that in many hospitals hepatitis patients are cared for on open wards when isolation in separate rooms is not possible. Their beds should be placed alongside wash basins so that staff members can't forget to wash their hands. Immunizing nurses and other employes who come in direct contact with the patients is also suggested, although it is not considered necessary to give immune globulin to all staff members routinely on the chance they might be exposed to infection.

In a handbook entitled "Viral Hepatitis" — which could profitably be

What Hospitals and Doctors Should Be Doing About Hepatitis

(Procedures Suggested by the U.S. Public Health Service for the Control of Viral Hepatitis)

HOSPITALS:

1. Establish a unit where all hepatitis patients can be cared for and where unit isolation rather than individual isolation can be practiced. If possible, nursing and auxiliary staffs assigned to this unit should not care for other patients.

2. Instruct nurses in the importance of appropriate technics:

(a) Patients should have individual equipment such as thermometers, bedpans and utensils.

(b) The attendant should wear a gown to protect the uniform during the time that nursing care is given and the patient's equipment is handled.

(c) Bed linens of hepatitis patients should be handled separately from other linen. Separate containers should be provided so that contaminated linen can be placed in the C.D. laundry bag at the door of the room or unit. The bag should be closed when not in use and while in transfer to the laundry. Laundries usually wash contaminated linen after other hospital linens. The laundering processes used in modern institutions are usually adequate to free soiled linen of pathogenic material.

(d) Disposable paper cups and dishes are recommended. When these are not practicable, the patient's utensils should be handled separately, but may be washed with other dishes since the machines employed will usually clean them sufficiently to remove all infectious materials.

(e) Nurses, attendants and physicians should wash their hands thoroughly immediately after handling patients or any equipment or supplies that came in contact with them.

(f) Bedpans should be sterilized, either by steam under pressure after each use, if possible, or by boiling for 15 minutes at least once a day. In disposing of stools and urine, bedpans may be emptied directly into the hopper or toilet if the hospital wastes enter a treated municipal sewerage system or proper septic tank. Liquid and solid food wastes should be handled in the same way.

3. Administer gamma globulin in a dosage of 0.01 cc.* per pound of body weight to nurses, laboratory workers, and auxiliary staff caring for hepatitis patients. Caution them that while they may show no signs of hepatitis because of the passive protection received,

*0.06 is recommended by some authorities.

used by hospital administrators and infections committees as a textbook — the Communicable Disease Center has set forth detailed procedures to be followed in the control of the disease. Some of these procedures that apply specifically to hospitals and medical staffs are reproduced in the accompanying box on this and the opposite page.

Serum Hepatitis. The first commandment in controlling serum hepatitis is: "Don't give blood transfusions unless they are absolutely necessary." Above all, don't give one-pint transfusions just to make the patient "feel better." He'll feel a lot worse if he turns up with hepatitis a few months later, and the hospital will feel worse than that if he sues.

In an article emphasizing the risks involved in one-pint transfusions, Dr. Robert S. Myers, executive assistant director of the American College of Surgeons, stated that "in 1959, approximately 5 million pints of blood were given by transfusion to patients in the continental United States," and added that this represents a considerable danger to the recipients of these 5 million transfusions from, among other things, hepatitis. "Medical staffs of hospitals," Dr. Myers warned, "should review the indications for blood transfusion and should reduce the number of these given needlessly."[8]

Medical staffs of hospitals should also make strenuous efforts to screen blood donors, Dr. Capps believes. While the importance of rejecting as blood donors all persons with a known history of hepatitis, or even exposure to the infection, has long been accepted, some authorities say that performance of liver function tests to screen out possible carriers is not worth the effort. Dr. Capps has no patience with this view. "It's silly to say you shouldn't do something," he contends. "No one claims that all possible carriers can be picked up, but some of them certainly can be eliminated by relatively quick and simple tests — the test for bile in the urine, for example, or one of the flocculation tests on blood." He thinks hospital infections committees should require that all potential donors be given the bilirubin test.

Another recommendation, on which there is general agreement, is to avoid administering plasma. Pooled plasma, even when it has been treated by irradiation or being allowed to stand for six months at room temperature, must still be regarded as potentially hazardous.

Maintaining rigid standards in cleaning and sterilizing syringes, needles, lancets and intravenous equipment and eliminating the multiple dose per syringe method of giving injections are essential, and obvious, requirements for the protection of both patients and staff.

The development of disposable needles and syringes has been greeted with enthusiasm by public health officials and the medical profession generally, but they still warn against re-

they may still be able to transmit the infection to others. Gamma globulin, therefore, is no substitute for cleanliness.

4. Autoclave all needles, syringes, glassware and instruments used for intravenous, intramuscular or subcutaneous injections for at least 30 minutes at 15 pounds of pressure after each use. Individual syringes and needles must be used. Lancets used to obtain capillary blood for laboratory determinations should be disposable.

5. After a patient's discharge, sterilize with steam all articles of equipment that can be handled in this manner. Those which would be damaged by heat or which do not lend themselves to this type of sterilization should be thoroughly cleaned with soap and water and soaked for 24 hours in a solution of 0.5 per cent iodine — 70 per cent ethyl (or isopropyl) alcohol. Thermometers should either be given to the patient to take home or should be cleaned and sterilized by the latter method.

6. The collection of blood from donors for transfusions should be discontinued and blood should be obtained from other areas until the outbreak is at an end. This is suggested because it has been shown that the virus of hepatitis A exists in the blood stream during the incubation period and the early acute stage of hepatitis.

PHYSICIANS:

1. Report promptly all cases of hepatitis to the local health unit. Report suspected as well as proved cases.

2. Administer gamma globulin promptly to all household contacts of cases.

3. Follow household contacts carefully, even though gamma globulin was given, to determine if secondary cases developed.

4. Maintain a high index of suspicion, and order all patients with suspicious illnesses to stay at home and to remain in bed.

5. Encourage personal cleanliness.

6. Exercise particular vigilance in the sterilization of all needles, syringes and other instruments by autoclaving or boiling.

7. If possible, avoid elective surgical procedures when the community attack rate is high. The patient might be in the incubation period of hepatitis, and the trauma of the operation, plus the toxic effect most anesthetic agents have on the liver, might lead to very severe, prolonged illness.

Reprinted by permission from: Eichenwald, Heinz F., and Moseley, James W.: Viral Hepatitis — Clinical and Public Health Aspects. Public Health Service Pamphlet 435. Communicable Disease Center, Atlanta, 1959.

laxing the rules of aseptic technic.

Finally, it is strongly recommended that hospitals should take some responsibility for follow-up and reporting on patients who have had blood transfusions. This is done in some areas — New Jersey is one — but not enough. Because of the long incubation period of Virus B, patients who have received blood or other parenteral fluids don't develop the disease until weeks or months after their hospital stay. And unless they return to the same hospital for treatment, or unless physicians report any cases of serum hepatitis they see, the connection between the initial hospitalization and the outbreak of hepatitis will probably not be made.

The Epidemic Intelligence Service of the Communicable Disease Center is ready and willing to send teams to investigate outbreaks of hepatitis and trace them to their source.

Case-finding, which is an imperative need if hepatitis is to be brought under control, calls for the cooperative efforts of all groups involved — including hospitals.

Thus far, no one has pointed an accusing finger at hospitals as being specifically responsible for the spread of hepatitis. But someone might, and responsible medical authorities hope that hospitals will recognize that such outbreaks as the one in New Jersey, which killed 14 patients, could happen to them — in the outpatient department, for example.

How Doth the Busy Little Oyster Carry Hepatitis?

At first glance, there would seem to be no connection between a bed of oysters lurking on the bottom of a contaminated river and a 19 year old hospital orderly who doesn't eat oysters.

Dr. J. O. Mason

It took many glances and exercise of the relentless thoroughness for which trained epidemiologists are noted to make the connection, which has a moral for hospitals.

Early this year, Dr. James O. Mason, chief of the Communicable Disease Center's surveillance section, responded to a request from the navy that he come to Pascagoula, Miss., to investigate a reported outbreak of infectious hepatitis there.* The navy was in the process of outfitting nuclear submarines and became alarmed at the possibility that its personnel might contract the disease.

On February 6, two days after Dr. Mason arrived in town, only six cases of hepatitis had been officially reported. Knowing that the official reports are only a "reflection of what is really going on," as he puts it, Dr. Mason assumed there must be more. The only way to find out, he reasoned, was to ask the people who know best: the doctors.

Accordingly, Dr. Mason went to the hospital, settled down in the doctors' lounge and, as each man entered, introduced himself and explained his quest. His technic paid off. The doctors told him of 35 cases they had seen this year and 25 additional cases they had picked up in 1960.

Because he wanted to get a fast case count, Dr. Mason interviewed the hospitalized hepatitis patients to learn as much as he could about the source of their illness.

The first thing he learned was that this organism was behaving in a most erratic fashion. For one thing, the age distribution was wrong. Infectious hepatitis usually attacks children in the 5 to 19 year age group. In Pascagoula, the majority of the patients were between 20 and 40 years old. And as a rule, adult cases are secondary, *i.e.* they develop as a result of family contacts. This did not obtain in the Pascagoula outbreak. These adult patients were primary cases.

Another variation was in the mode of transmission. Infectious hepatitis is commonly carried by person-to-person contact. But these patients apparently had no contact; they didn't even know one another. So how did they get the disease?

Brooding on the possibilities, Dr. Mason came up with the idea that Pascagoula is a fishing area, and there could be a connection between seafood and the outbreak. While water has frequently been documented as a source of hepatitis infection, food seldom has, but the idea seemed to be worth following up.

When he questioned the patients about their consumption of raw seafood, the answers proved that the idea was well worth following up. Seven out of seven patients had eaten raw oysters and in every case the oysters had been taken from a bed of the river that was known to be heavily contaminated.

Hospital officials in Pascagoula were upset by the influx of hepatitis cases, Dr. Mason reports, and confused about what they should be doing to protect other patients and the staff. Dr. Mason recommended the usual handwashing precautions and bedpan isolation plus administration of immune globulin to nurses and other staff members who came into contact with the patients. These recommendations were duly followed, but, even so, one nurse and the aforementioned 19 year old orderly came down with infectious hepatitis.

In the case of the nurse, this was not too surprising. She had been in direct contact with the patients. It was the orderly who demonstrated how long is the reach of viral hepatitis. He didn't eat any raw oysters. He wasn't in contact with the infected patients. All he did was collect and sort the linens from their beds. — *Q.E.D.*

*Morbidity and Mortality Weekly Report, April 7, 1961.

Dr. Langmuir and his associates see the infections committee as the strongest defense hospitals can present against charges of negligence. But the mere existence of a committee is not enough, they warn.

"Infections committees," Dr. Langmuir said, "must maintain a continuing surveillance of hospital acquired infections, whether they are serum hepatitis, traceable to faulty technics or transfusion, or infectious hepatitis, staphylococcal or other bacteriological infections traceable to inadequate isolation and aseptic technics. Only by knowing what is going on currently can the infections committee institute controls promptly and maintain preventive measures at the highest level."

There's no rest for a hospital. ■

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Look for Hepatitis, Chicago Commissioner Urges

A 100 per cent increase in cases of infectious hepatitis was reported in Chicago the first three months of 1961 (through March 29) over the same period in 1960, according to Dr. Samuel L. Andelman, who succeeded the late Dr. Herman Bundesen as commissioner of health. In actual figures, cases reported the first three months of 1960 totaled 93, with five deaths, while those reported in 1961 totaled 189, with nine deaths. Serum hepatitis increased, too. One case has been reported this year; last year the figure was 0.

Dr. S. L. Andelman

Dr. Andelman and Frank E. Bauer, chief statistician for the board of health, explained it was possible that some of the cases reported as infectious hepatitis could actually have been caused by the serum variety, although the biostatistics division attempts to separate the two types of cases.

The board of health has established cordial working relations with the medical record librarians of Chicago hospitals, with the result that the hospitals, in general, "are alert to the problem and are doing a good job of reporting," Dr. Andelman stated with satisfaction.

Although he is satisfied with the performance of the hospitals and medical staffs in their handling of hepatitis cases, Dr. Andelman does not discount the seriousness of the outbreak, which, he points out, is not just a Chicago problem but a national and international one.

"We are not fearful," he said, "but we certainly are concerned. We can't hide our heads and say that this increase in hepatitis is due merely to better reporting. And it's above and beyond the regular cyclical increase. The virus must be increasing."

Asked what specific measures he would like hospitals to take, Dr. Andelman stated that the health department looks to hospital infections committees for early detection and early reporting.

The health commissioner is an enthusiastic advocate of immune globulin as a protection against infectious hepatitis. He believes with Dr. Krugman (see page 70) that the dosage should be adjusted to the amount of exposure to the disease. Doctors and nurses who are in close contact with patients, he says, should have a higher dosage than is ordinarily given or they won't be protected.

The possessor of a degree in hospital administration (among others), Dr. Andelman is imbued with the idea that community hospitals have a duty to patients that extends beyond their actual stay in the hospital. "Administrators and medical staffs (and, of course, we have to educate boards of trustees to this, too) have to remember that a hospital is different from a hotel in relation to its guests. When a guest leaves a hotel, he's on his own; the hotel has no further responsibility for him. But a hospital that professes to serve the public has the responsibility to look after its patients even after they leave."

He and Mr. Bauer agreed that the infections committee might devise a simple follow-up form to be sent to patients who have received blood transfusions or other parenteral injections while they were hospitalized. Such a form, they think, should be helpful in tracking down cases of serum hepatitis.

Dr. Andelman urged hospital administrators to support their infections committees in every way possible. "They should respect — and carry out — the wishes of the committee," he stated, "and not treat its recommendations lightly. Hospitals can't just sit back and say 'it can't happen here.' It can happen anywhere."

One thing Dr. Andelman is quite sure won't happen. In the midst of the turmoil over viral hepatitis, Chicago was afflicted with an outbreak of typhoid fever, which necessitated mass inoculation of school children. In response to the question: "What effect are the inoculations likely to have on the spread of hepatitis?" the commissioner answered: "None whatever. We're using only disposable needles and syringes. Nobody's going to get hepatitis out of this."

Consultants Hear Criticism of Laboratories: Directors and Hospitals Accused of Profiteering

Lucy Freeman

BETHESDA, MD. — A grim picture of the inadequacy of the modern hospital laboratory, out of date even as a new hospital opens its doors, was painted at the midyear meeting of the American Association of Hospital Consultants held at the Clinical Center, National Institutes of Health, here last month.

The hospital laboratory, which is assuming a central role in medicine, has been, and is today, "the most exploited sweatshop in medical practice," it was charged by Dr. George Z. Williams, chief of the clinical pathology department of the Clinical Center. He declared that hospital administrators are exploiting the laboratories to pay deficits in the laundry, building maintenance, housekeeping and other "nonincome producing departments."

Accusing the laboratory director and the hospital together of "profiteering," Dr. Williams said they have tolerated "and too often encouraged" low pay for technicians, higher fees and other means to increase laboratory income because the patient will more willingly pay excessively for the "science" of the laboratory than "the mundane services of nursing and food."

Laboratories Poorly Designed

Now hospitals today are completed with poorly designed, badly located laboratories "already grossly inadequate to support modern medicine on the day the hospital opens," he said. Most laboratories throughout the nation are "sadly understaffed and technicians inadequately trained.

"The traditional inadequacies and remarkable deficiencies of hospital laboratories have been perpetuated by overworked pathologists lost in ardent pursuit of surgical anatomy, hospital administrators plagued with deficits and auditors, and architects puzzled by our indifference to their lack of guidance," he put it.

"Tests per patient will increase at a rate of 10 per cent per year for many years, and present laboratory space and facilities must be doubled in 10 years to meet the needs, possibly doubled again the following decade," he predicted.

"The intelligent, well read patient will demand rational diagnosis, treatment and preventive management supported by scientific facts. Remember he lives in a fantastic atomic space age of exploding technology and will expect the same in medicine," he warned.

Dr. Arthur E. Rappaport, director of laboratories for the Youngstown Hospital Association, Youngstown, Ohio, described the battle between the consultant and laboratory director, with the laboratory director thinking: "How much space do I need to accomplish all the work I have to do, including research, training and the practice of medicine?" while the consultant is concerned with, "How little space do I have to give that fellow in order to get the job done?"

He also emphasized the complexity of the modern laboratory and said its total test load calls for far more space than is being allotted by consultants.

The two-day meeting was filled with lively discussion on topics of interest to consultants, from the moment John N. Hatfield of Chicago, president of the association, called it to order in his quiet, non-waste-a-word voice with the words, "We're all present and accounted for — Jack Masur says so." In his opening remarks, Mr. Hatfield declared it was gratifying to see such an unusually large turnout.

Dr. Masur, director of the Clinical Center and member of the association, was host for the meeting, welcoming the members to what he described as "the Taj Mahal of Bethesda." The program included a tour of the Center and the showing of a film depicting some of its activities. Members were also dinner guests at the Army and Navy Club in Washington.

First papers delivered were on the controversial subject of the size of the nursing unit in the average general hospital. Dr. Frank Sutton of Dayton, Ohio, declared he believed "the large nursing unit is more economical to construct and operate," and that "quality of care appears to be more a matter of adequate staff and proper supervision than the size of the unit."

Dr. Herman Smith of Chicago made a plea for flexibility and independence, even though he admitted he was prejudiced in favor of the large nursing unit of about 60 beds. He said, "We need, however, to be flexible for a long time until we have conducted far more experimentation."

Finds Smaller Units Preferred

Dr. Albert W. Snoke of New Haven, Conn., chairman of the program committee, said that in his hospital, Grace-New Haven Community Hospital, he found the smaller nursing unit preferred by the nurses. He held it was a question of "how many patients can the ordinary nurse — not the best nurse in the world but the average nurse we all employ — care for and do an adequate job." He pointed out that hospitals today were "getting sicker patients who need more intensive care and this should give pause to the larger unit."

Other questions and comments: Joseph G. Norby of Milwaukee — "Is it not the lack of instruction and direction that might affect the quality of patient care rather than the size of the unit?"

Dr. G. Harvey Agnew of Toronto, Ont. — "I still favor the smaller unit. The nurses and doctors are not keen about the larger unit nor are the patients as happy. They run the chance of not seeing the same nurse twice."

Otis N. Auer of Glen Ridge, N. J. —"Is this question not a tug-of-war between economics and quality of patient care?"

To this last question, Mr. Hatfield replied, "To my mind, it's a matter of distribution of personnel. A certain class of patient requires more care. Economics and care go hand in hand. What we're concerned with is the adequate care of the patient."

A study on the use of an administrative deputy to the head nurse was reported on by Ruth L. Johnson,

(*Continued on Page* 168)

The author is a medical and science writer, New York.

Exposed concrete with vinyl plastic paint provides low-cost exterior for Grays Harbor Community Hospital, shown on next two pages.

A newly developed guide helped planners fit Grays Harbor Hospital to its community

They Built This Hospital 'By the Book'

PROGRAMING a hospital on the basis of a "how-to-plan-it" guide was a new idea in the state when Grays Harbor Hospital, Aberdeen, Wash., volunteered to be the first to try the plan.

Although the *Guide to Programing Hospital Facilities*, developed by the Hospital and Home Section of the State Department of Health, was still in a preliminary draft, the completed hospital gives testimony that the idea is sound and that the guide will prove a valuable aid to planners.

The design of the obstetrical department (see page 79) exemplifies the usefulness of such a plan.

The program indicated that the occupancy of this department fluctuated considerably, and at times it did not have more than a few patients. Therefore, the program indicated that the O.B. department be placed so one staff could take care of labor rooms, delivery rooms, postpartum patients, and nurseries; and when the department had a low census some of the beds could be made available to surgical patients.

The functional program also indicated a large outpatient load and for this reason the x-ray and physical therapy departments and laboratories were located on the first floor – easily accessible to both outpatients and inpatients. The operating suite is also on the first floor to be convenient to x-ray and laboratories.

The nursing unit for medical patients is on the third floor. This unit also includes facilities for pediatric patients. Architect for the hospital was John W. Maloney, A.I.A., Seattle.

To permit expansion, the main wing was designed to carry two additional floors, thus providing two more nursing units – or an increase of approximately 80 beds. As the diagnostic and treatment facilities are on the first floor, these could be expanded horizontally.

Both Ronald Orr, manager of the hospital, and Tibor Freesz, project architect, express the belief that programing has made Grays Harbor Community Hospital "a hospital built to be measured not in square footage, but in service to the community."

This nursing station is located in center core between the corridors.

This Guide is a valuable asset for designing hospitals. It outlines the steps to be followed in analyzing needs in a manner that provides the architect with the most important information necessary for good planning and forms a basis for an intelligent review of architectural plans by the sponsor and public health agencies. — *The Architects, Grays Harbor Hospital.*

Kitchen on ground floor is designed to handle heated carts.

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects, and the state agency. A similar award will be made each month.

OUTLINE OF CONSTRUCTION COSTS

Total project cost $1,742,531.28*

No. of beds 99
(planned for 80 additional)

Cost per bed $17,601.32*

Total square feet 61,500

Square feet per bed 620

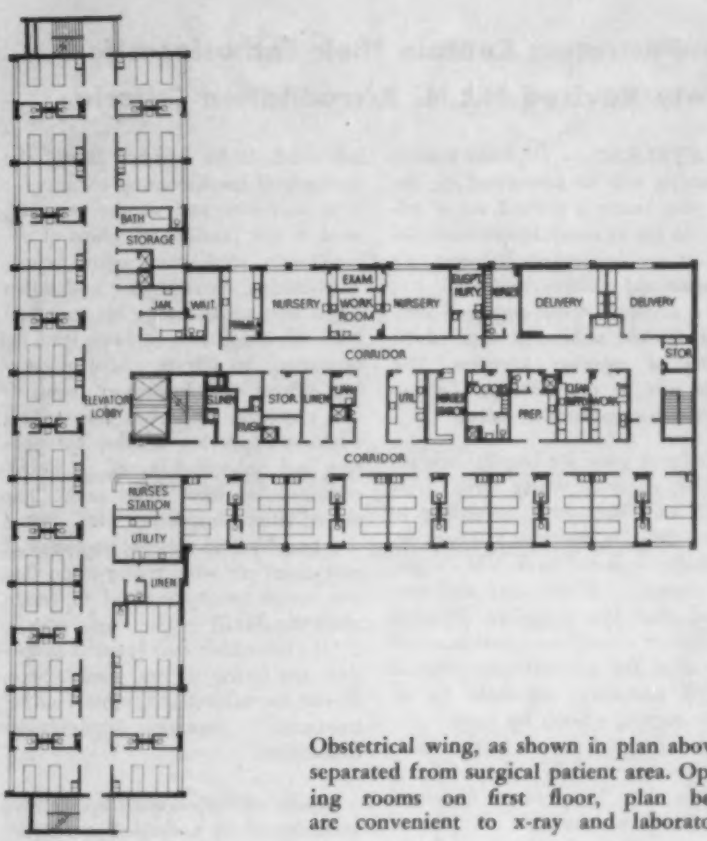
Cost per square foot $23.09

Total cubic feet 727,600

Cubic feet per bed 7,340

Cost per cubic foot $1.95

*Includes cost of Groups I, II and III equipment, architect's fee, and cost of site.



Obstetrical wing, as shown in plan above, is separated from surgical patient area. Operating rooms on first floor, plan below, are convenient to x-ray and laboratories.

Administrators Contain Their Enthusiasm for Newly Revised N.L.N. Accreditation Criteria

CLEVELAND. — Diploma schools of nursing will be accredited for the next year under a revised set of criteria. As far as many hospital administrators are concerned, however, it's the same old monkey business.

The revisions were approved during a spirited session of the N.L.N. council of member agencies. The group met at the National League for Nursing convention here.

On hand were 90 hospital administrators, many of whom were "frustrated and dismayed," according to one of them, to find that the new accreditation criteria were still "vague and unusable." Many were also convinced that the American Hospital Association should now withdraw its support of the accreditation program and, if necessary, undertake to accredit nursing schools by itself.

Some hospital people at the meeting, however, while acknowledging progress has been slow, indicated that they are convinced the present arrangement is the best available. They argued that it would be a mistake for A.H.A. to change its policy in regard to it.

Also attending the session were representatives of 531 of the 639 diploma schools that are agency members of the N.L.N. Department of Diploma and Associate Degree Programs. Although discussion of the revisions was impeded by a series of parliamentary snarls, it was plain that a sizeable group of these registrants also believed the criteria still left much to be desired, as did the methods of implementing them.

In corridors and at the meeting, most of the familiar criticisms of accreditation were once again heard: A Michigan administrator said not a single hospital school in his state had been revisited without being put on probation. An Illinois school of nursing official said inspectors came to her city and approved one school while disapproving another for policies both schools followed. A Sister-administrator from Ohio said, "The accreditation inspector who visited our hospital was so contemptuous of everything we were trying to do that our entire faculty wanted to resign after she left."

"It's incredible that hospital people who are trying to run good schools should be subjected to this kind of treatment," another administrator commented.

Much of the dissatisfaction was summarized in a resolution submitted by Dr. Martin Steinberg, director of Mount Sinai Hospital, New York, and Grace Worman, director of the hospital's school of nursing. The resolution, which with several others was referred to the steering committee, stated that the new criteria "do not define adequacy in any measurable standard that could be useful to the schools in self-evaluation. . . ."

Moving on, the resolution noted that the revisions were "in fact and admittedly merely a reorganization of the criteria with a view to retaining the philosophy and intent of the existing criteria and, therefore, cannot constitute a definitive or substantive change in the direction of transforming the criteria into significant indices or standards. . . ."

Taking a poke at the over-all N.L.N. direction of the accreditation program, a pet target for hospital administrators, the resolution warned that "the growing dismay and lack of direction where there should be confident direction and encouragement toward easily definable goals constitutes a growing hazard to the education of more and better qualified nurses. . . ."

Following a tangled series of motions and amendments and amendments to amendments that took several hours, it was voted to accept the revised criteria until a more satisfactory set could be developed. Members were asked to submit suggested changes to N.L.N. for consideration before the criteria were printed.

Acknowledging criticism of methods of applying the criteria, an N.L.N. official promised the assemblage that every effort would be made to improve these methods.

Buckling down to more pleasant business, the League:

— Approved a statement called "Opportunities in Nursing" that included a section describing characteristics of diploma and associate degree programs, but only after the motion to approve the statement was amended so that changes in this section made at the meeting could be incorporated into it.

— Reelected Lucile Petry Leone president of N.L.N. Mrs. Leone, chief nurse officer and assistant surgeon general, U.S. Public Health Service, will serve two more years.

— Approved hospital agency memberships in the department of hospital nursing, which heretofore had accepted only personal memberships.

— Created an N.L.N Department of Practical Nursing Programs, thus giving this group equal organizational status with other types of nursing education programs in the League.

— Heard Dr. Ralph E. Dwork, director of the Ohio department of health, characterize modern concepts in health care as "one ill, one pill, one bill." ■

Sample Change in N.L.N. Accreditation Criteria

OLD ACCREDITATION CRITERIA	REVISED CRITERIA
"The general changes in behavior which the school endeavors to help its students bring about in themselves (objectives) have been identified by the faculty and enunciated in terms of: a—the student as a person b—professional abilities, relationships, and responsibilities c—citizen responsibilities."	"The faculty has formulated objectives which are enunciated in terms of the changes in behavior which the school endeavors to help students bring about in their development as persons, nurses and citizens."

Revised accreditation criteria illustrate how the criteria were edited and reorganized without changing their underlying philosophy and approach, a circumstance that caused some discord at the meeting of the N.L.N. council of member agencies.

Are Circular Units Overrated?

They certainly are, says this architect, who submits that comparison of round and rectangular units gives the edge to the rectangles in almost every way

Herbert P. McLaughlin

A 1958 graduate of the Yale School of Architecture, Mr. McLaughlin is in the army now — in the San Francisco Medical Construction Liaison Office of the Surgeon General. When he resumes civilian life this summer, he plans to stay in San Francisco working with an architect.

THERE has been a great deal of publicity recently about circular nursing units. For the most part, the publicity has been favorable. This is hardly surprising, since the information on which the publicity is based probably originated with either the architect or the administrator of the hospital for which the unit was built.

Magazine articles and brochures describing the circular units have made such sweeping claims as "cuts nurses' travel by 37 per cent" or "reduces exterior wall by 32 per cent." Unfortunately, the standards used to arrive at comparisons such as these have rarely been specified. If circular nursing units are the panacea they are so frequently claimed to be, their case could, and should, be easily proved.

Comparisons generally are valid only when the terms of comparison are clearly understood. There have been a number of studies recently comparing the relative efficiency of various nursing units. However, the value of these studies has been greatly diminished because the nursing units studied bore only a very slight resemblance to one another.

In the comparison of nursing units, the first "term" with which the planner is concerned is the type of patient to be treated. Comparisons of distance, travel time, and other factors in a unit planned for treatment of patients requiring intensive nursing service and another unit planned for ordinary or "intermediate" care as the term has been used at the Manchester Memorial Hospital, Manchester, Conn., would have no more validity than a comparison of unit heating costs between hospitals in Florida and Saskatchewan.

The other major "term" of comparison is the type of physical accommodations provided. The type of patient room and, particularly, the type of support facilities provided must be similar if accurate comparisons are to be made.

In this study, I have attempted to base all comparisons on plans providing approximately equal physical facilities for patients in the same

categories of patient care. The types of travel used to measure operational efficiency were derived from the report by Pelletier and Thompson at Yale University.[1]

I believe the Pelletier-Thompson measurements of importance of various travel patterns are the best index of nursing unit efficiency that have yet been developed. The first six of these typical traffic patterns have been used in this study.[2] These six constituted 71.6 per cent of the travel in the nursing units Pelletier and Thompson studied. When measurements involving patient bedrooms were made, distance to the head of the patient's bed was calculated, since the majority of travel to the patient room involves this specific trip.

[1]Pelletier, Robert J., and Thompson, John D.: Yale Index Measures Design Efficiency. Mod. Hosp., 95:73 (November) 1960.

[2]In order of importance, they are: (1) patient rooms-patient rooms (2) nurses' station-patient rooms, (3) utility room-patient rooms, (4) nurses' station-utility room, (5) nurses' station-elevator lobby, (6) nurses' station-medication closet.

Twelve-Bed Intensive Care Unit

One of the most widely publicized circular nursing units has been the 12 bed, experimental intensive care unit at the Methodist Hospital in Rochester, Minn. (Fig. 1).

This unit was built and operated by the hospital as a research project. The study included a comprehensive analysis of the working efficiency of the experimental unit in comparison with another unit which was similarly occupied and staffed but rectangular rather than circular in plan.

The rectangular unit was a modified, single corridor nursing floor of the type which is common in many hospitals today. The study also compared patient, staff and family satisfaction in both units.

In the Rochester experiment, there were two basic differences between the nursing units: (1) The circular unit provided direct visual supervision into the patients' bedrooms from the nursing station and the corridors, and (2) distances from the centrally located nurses' station to the patients' rooms were substantially shorter in the circular nursing unit than in the control unit.

It is impossible to contest the conclusion of the Rochester investigators that the circular unit was much the more successful of the two studied. However, it is certainly arguable that the success of the unit is not in any way attributable to the fact that it is circular.

Unfortunately, the study makes it appear that it *is* the circular shape that is responsible for the success of the experimental unit. The principal report of the research project was titled, "Comparisons of Intensive Nursing Service in a Circular and a

TABLE 1: Comparison of travel distances, area sizes, and length of exterior walls in circular and rectangular units shows that travel distances are virtually the same; the area required for 12 and 24 beds in the rectangular unit is approximately two-thirds that of the circular arrangement.

	AV. DIST. PATIENT BED TO PATIENT BED	AV. DIST. NURSES' STATION TO PATIENT BED	AV. DIST. UTILITY ROOM TO PATIENT BED	DIST. NURSES' STATION TO UTILITY ROOM	DIST. NURSES' STATION TO ELEV. LOBBY	DIST. NURSES' STATION TO MEDICAT. ROOM	TOTAL AREA	AREA PER BED	LENGTH OF EXTERIOR WALL
TWELVE BED NURSING UNIT									
RECTANGULAR	2	1	2	2	1	1	1	1	1
	33.8	22.5	41.9	31	40	4	2,570	214	195
CIRCULAR	1	2	1	1	2	1	2	2	2
	32.7	23.4	39.8	30	44	4	3,744	312	203.3
TWENTY-FOUR BED NURSING UNIT									
RECTANGULAR	1	1	1	2	1	1	1	1	1
	46	32.5	44	33	57	4	3,645	154.2	247.5
CIRCULAR	2	2	2	1	2	2	2	2	2
	50	34.2	48.6	30.5	58	10	6,135	255.5	257.3

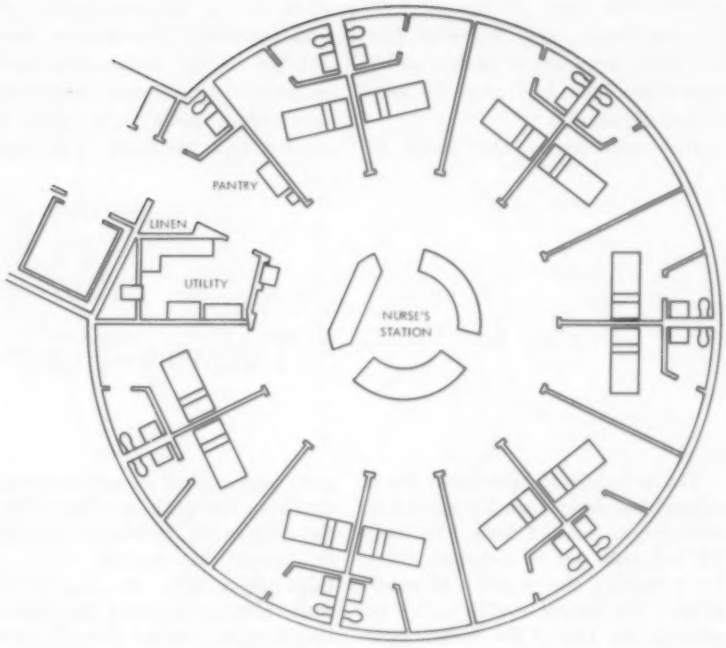


FIG. 1 (right): This is the 12 bed circular unit developed at Methodist Hospital, Rochester, Minn. The circle plan proved to be highly efficient, according to the reports of the investigators at Rochester.

Rectangular Nursing Unit." In addition, the report itself stated that many other *shapes* were considered and discarded in favor of the design adopted for the experimental unit.

It is possible, nevertheless, to design a rectangular unit which in many respects equals and in others surpasses the circular unit (Fig. 2). As shown in Table 1, these rectangular and circular units are virtually the same in travel distances. The rectangular unit, however, is clearly superior in other respects.

Study of the plans (Figs. 1 and 2) will show that the view from the nurses' station and the corridor into the patient's room is significantly better in the rectangular unit. The number of patients viewed from a normal corridor position was 10 in the rectangle, eight in the circular; from directly outside the patient's door it was seven in the rectangular unit and five in the circular. A further advantage of the rectangular plan is that if somewhat larger patient bedrooms are desired, expansion can be accomplished easily at little cost in square feet, while expansion of bedrooms in the circular units would create a great deal of additional unusable area.

It seems likely that the rectangular unit would also be markedly superior to the circular in economy of construction.

The area of the rectangular unit is roughly two-thirds that of the circular unit (Table 1). With the cost of air conditioned hospital construction at

FIG. 2 (below): The plan indicates that a rectangle offers advantages over the circular unit in some respects: The angle of view from patient's room to nurses' station is superior, and the rectangular unit can be expanded easily at little cost in square feet and without waste of usable space.

approximately $40 per square foot, including fund raising, financing, fees and other costs, the difference of 98 square feet per bed must be considered significant.

The many corners that would be called for in this rectangular plan would certainly be relatively expensive, but circular wall construction is also more expensive than straight wall construction, particularly when the circular wall intersects with many other walls, as is the case in this unit.

Summary: There is little or no advantage either operationally or financially in constructing a circular rather than a rectangular 12 bed nursing unit.

Twenty-Four-Bed Nursing Unit

The principle of open-view, direct supervision design can be applied to units larger than 12 beds. The basic 12 bed unit can be enlarged either by increasing the number of rooms around the nurses' station or by increasing the size of the bedrooms to accommodate two beds instead of one. Of the two approaches, the latter is the more feasible.

If more than 12 rooms 11 feet wide are planned in a circular nursing unit, the central, open area becomes so large that supervision is made difficult. In this study, the 11 foot width is used for all semiprivate bedrooms; this dimension favors the circular configuration, which suffers larger increases in total area than does a comparable rectangular unit as the width of the bedrooms is increased.

The type of bedroom used in this rectangular unit is somewhat unusual. At least two hospitals using this room arrangement are now under construction. The position of the toilet on the exterior wall eliminates the wasteful subcorridor created when the toilet is placed on the corridor wall. This arrangement also shortens the distance traveled from the corridor to the head of the patient bed. Several versions of this arrangement are shown in Figure 3.

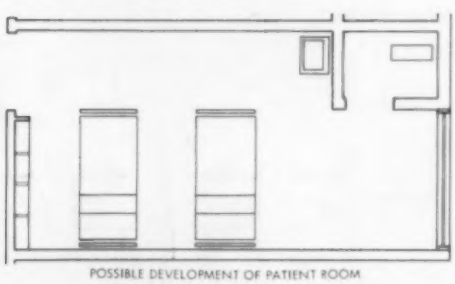
Figure 4 shows such a 24 bed circular unit, similar to some that have been built and publicized; Figure 5 presents a rectangular unit of the same type. The comparisons in Table 1 demonstrate the clear superiority of the rectangular unit in both function and construction.

Again, view from the nurses' station to patients' rooms is superior in the rectangular unit. Once again, the rectangular unit would probably be much cheaper to construct.

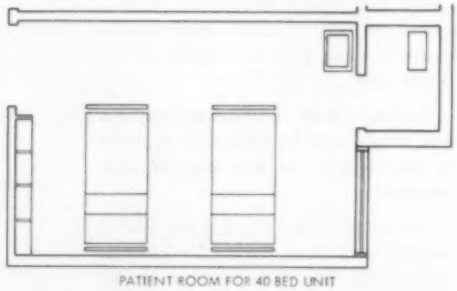
Whatever the plan, however, there is a serious question that this particular type of unit has a proper place in any hospital planning scheme. It appears to involve an essential contradiction of purpose; the general design of the unit is intended for intensive care, but semiprivate rooms in 24 bed units are not well suited for intensive care patients.

Direct visual contact between nurses' station and patients' rooms and between room and room is more a social than a medical consideration for medium care patients. This type of patient is fully conscious and aware of his surroundings during waking hours, easily capable of signaling the nurse when he requires any care or service whatsoever. Given this situation, some nurses say they still like to work on the principle of "see and be seen"; others feel the patient will make more, rather than

FIG. 3: The three plans shown below on this and the opposite page are all variations of the same room arrangement, which is being used in two hospitals now under construction. The position of the toilet on the exterior wall in this design eliminates the wasteful subcorridor that is created when the toilet is located on the corridor wall.



POSSIBLE DEVELOPMENT OF PATIENT ROOM



PATIENT ROOM FOR 40 BED UNIT

FIG. 5: One version of 24 bed intensive care nursing unit is shown in the rectangular plan.

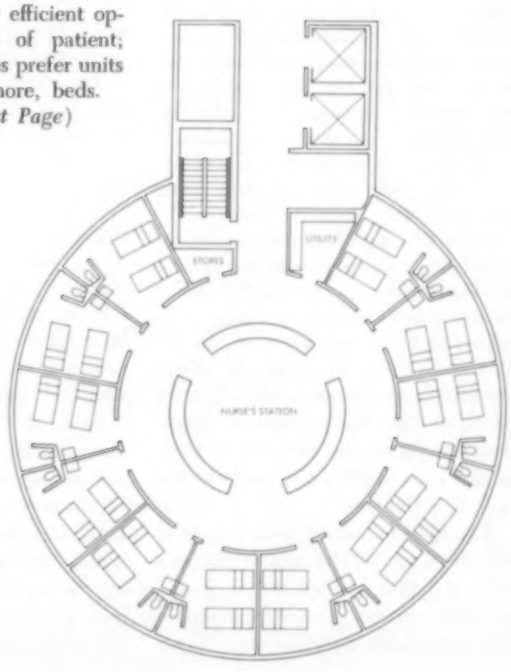
fewer, calls if he can see the nurse. The Rochester study reporting fewer patient demands on the nurse who could "see and be seen," it will be remembered, was based on experience with *intensive care* patients and cannot be considered valid for ordinary or intermediate patients.

If there is some question about the desirability of the open-view plan for intermediate patients from the standpoint of the nurse, there is little question that the patients themselves generally prefer a degree of privacy not obtainable in this type of unit. Many patients were questioned during the present study; almost without exception they preferred to be concealed from the view of nurses, visitors and other patients on the unit. For patients who wish to observe corridor activity, an open door from a room in a conventional nursing unit is adequate. Especially, patients do not want to look into other patients' bedrooms or be seen from other bedrooms – an unavoidable exposure in any plan featuring a window in the wall on the nurses' side of the room. Even if the window is placed high on the corridor wall so that only a person standing in the corridor can see the patient in bed, when the bed is elevated, as it frequently is, the patient's eyes are at approximately the level of the eyes of a standing person, and the patient can easily see into other rooms.

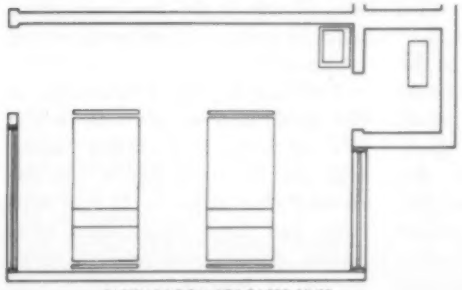
In addition, the 24 bed unit is small for true efficiency in caring for patients in the category of normal care. Previous studies, and most authorities, agree that a 30 bed unit is the minimum size for efficient operation with this type of patient; many planning authorities prefer units of 40 or 50, or even more, beds.

(*Continued on Next Page*)

FIG. 4 (below): A 24 bed circular unit similar to some that have already been built.

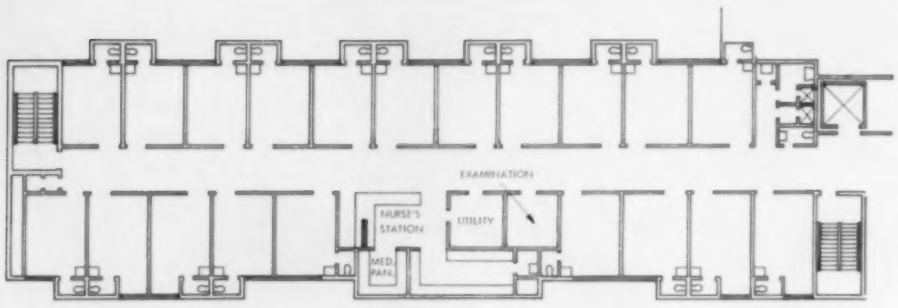


Another advantage of this arrangement of the rectangular unit is that it shortens the distance that must be traveled from the corridor to the head of the patient's bed.



PATIENT ROOM FOR 24 BED UNIT

FIG. 6: The classic nursing unit design in this country is the single corridor unit plan like the one shown here.



Forty-Bed General Care Nursing Unit

Forty beds is the size selected for the study of a normal nursing unit. Generally speaking, most normal care nursing units being built today contain from 35 to 40 beds. This size seems to work well with modern nursing practice.

A minimal amount of support facilities were designed into the nursing units considered in this study. Only one utility room is provided, and the nurses' station and examining room could be considered small. There is no patient lounge or tub room. This approach was taken because it was felt that it would benefit the circular nursing units studied. The geometry of the circle makes it react to increases in the size of individual spaces more acutely than does any other common shape.

Generally, nursing units can be divided into two categories, single and double corridor, or to use other terms, simple and redundant circulation patterns. Unit designs such as the L, T, and H, cross, swastika and others are merely variations or combinations of these two basic patterns. Space does not permit the inclusion of some of the commonest units, such as the L or T, in this study.

The classic nursing unit design in this country is the single corridor (Fig. 6). This unit has the advantage of clean, simple corridor circulation and supervision and low area. It has the disadvantage of few bedrooms directly across from the nurses' station and great length of exterior wall. Generally speaking, it ranks second operationally of the nursing units studied.

The double corridor nursing unit has become increasingly popular since the introduction of air conditioning as a regular feature of hospital design. Air conditioning makes this type of unit with its many interior spaces not only feasible, but also practical, since this type of design reduces the amount of exterior wall.

The double corridor unit shown here (Fig. 7) is typical. It has the advantages of the maximum number of patient rooms opposite the nursing station, short travel distances, low area and exterior wall figures. Supervision of the corridor is not as easy in this unit as it is in the single corridor unit; however, if the unit were manned, as in all probability it would be, with one nursing team assigned to each side of the corridor, supervision would be excellent.

None of the measurements of distance contained in this study make the assumption that the units would be divided into segments for operation. However, if they were, this would have the following effect: The figures on average distance, patient bed to patient bed, in the single corridor unit would decrease dramatically, making this unit the most efficient in this respect of all those studied. The other units studied would be affected only slightly by this change.

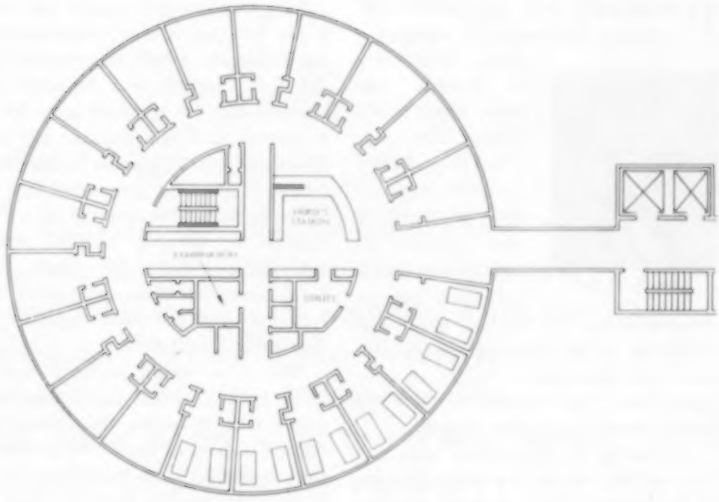
The third unit considered in this study is the circle with the beds facing toward the corridor (Fig. 8). This unit does not compare very well with the rectangular units in terms of either operational efficiency or economy of area. In addition, corridor supervision is poor and, whatever efficiency of operation there is, is dependent on extensive travel through the core of the unit. This type of traffic tends to be confusing to the point that it is generally avoided by nursing personnel.

The other type of circular unit shown has the bedrooms arranged in a more normal manner (Fig. 9). This nursing unit is not truly comparable with the others in the 40 bed category because it is a self-contained unit without connection to other facilities or nursing units. Even with this advantage the two rectangular units are superior in performance and construction.

This fact is a good illustration of the harsh laws of geometry which rule the design of a circular nursing unit, and, to a lesser degree, a double corridor unit. Since an 11 foot wide room and toilet combination in a circular nursing unit requires about 16 feet of exterior wall and is only

FIG. 7: The double corridor arrangement provides maximum number of patient rooms opposite the nurses' station.

FIG. 8: A 40 bed nursing unit designed in a circle with beds facing corridor.



16 feet deep, 40 of these rooms create a very large circle with a very large interior core. This core area is so large that the support facilities only half fill it, and elevators and an additional stair can be added. If another 16 foot space were added on the exterior wall so that a connector could be extended to another nursing unit, the entire circle and core would become unwieldy.

The fact that the core of this unit can contain two elevators is not, as it might at first seem, an advantage. Forty beds per floor is wasteful of vertical circulation, an expensive construction item. If this 40 bed nursing unit were, for instance, a part of a 200 bed hospital, five nursing floors would be required in addition to the one or two basic floors of the rest of the hospital. If this were to happen, at least three elevators would have to be accommodated, causing the omission of a vital support room. Additional problems would be created if more support facilities, such as utility or examining rooms, were required on each floor.

This example and that of the previously studied circular nursing units point out very clearly the inflexibility and inefficiency of the circular nursing units studied when compared to the rectangular.

Architects and hospital administrators should think twice before going around in circles. ■

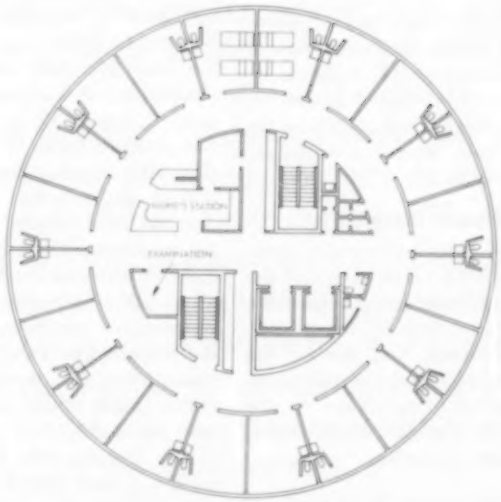


FIG. 9: This unit is self-contained without connection to any other nursing units.

Hospital's Legal Duty May Extend Beyond Provision of Emergency Care

John F. Horty

PROBLEMS may well occur concerning the hospital's continuing legal duty after a patient has been given emergency care.

John F. Horty

Such problems revolve around the question of the extent to which the hospital must assume responsibility for further care and treatment of the patient. Under certain circumstances, a failure to continue care may result in liability being placed upon the hospital.

Follow-up to emergency care can take at least three forms. Admission of the person as an inpatient may be indicated. Further outpatient treatment or referral to a physician may be necessary. Or the hospital may desire to transfer the patient to another institution.

Although there may be exceptions, the general rule is that once care of a patient is commenced, it should be continued until ceasing such care, or transferring the patient elsewhere for continued care, does not endanger his life or health.

Court Decides in New York

In a 1955 *New York* case, a woman suffering from a stab wound of the abdomen was taken to a charitable hospital. After examining the woman, an intern cleansed and dressed the wound, and arranged for the woman's transfer by ambulance to the city hospital. She died there during an exploratory operation.

In a suit brought against the charitable hospital, it was contended that the failure to admit the woman into the first hospital was because that hospital did not want to have her as a patient, and not because her condition did not appear to be an emergency. It was also contended that the delay in treatment occasioned by the transfer to the city hospital was a contributing cause of death. The court accepted these arguments and recovery was permitted against the charitable hospital.

This case would indicate that in *New York*, at least, once any emergency care is begun the courts may impose a duty to retain the patient in the hospital until discharge or a transfer to another hospital does not involve risk to the patient.

In a 1934 *Alabama* case, a child suffering from diphtheria was brought to a charitable hospital. The house physician swabbed the child's throat and gave an injection of antitoxin. The child's father was informed that the hospital's rules did not permit acceptance of patients with contagious diseases. Thereafter the child was returned home by auto and died soon after arriving. Suit was brought against the hospital on the theory that the child's death was caused by the weakening effect of the antitoxin, coupled with the exertion of the trip home. It was argued that having commenced emergency treatment the hospital had a duty to render ordinary hospital services, and the child's father should not have had to take her home.

The hospital was held not liable on the ground that it was a private corporation, not a public institution, and owed the public no duty to accept any patient not desired.

The court felt that the rule which prohibited the admission of contagious disease patients was a reasonable one, designed to protect the life and health of other patients, and that the fact that emergency care was rendered did not raise a duty on the part of the hospital to continue caring for the child as an inpatient.

It should be noted that in neither the *New York* nor the *Alabama* case is there any discussion of what duty, if any, required the hospital to commence emergency treatment in the first place.

Although the *Alabama* case would seem at first glance to state that charitable hospitals have prerogative to accept or reject prospective inpatients as they choose without regard to any obligation engendered by emergency care, one important additional factor is present. This is the fact that the child suffered from a communicable disease. The court may well have felt that, under the circumstances, the hospital's duty to prevent any risk of contagion to other patients outweighed any duty it might have to continue emergency treatment by admission of the girl as an inpatient. It should also be noted in passing that the *Alabama* case is almost 30 years old, and legal concepts in the hospital field have been changing rapidly.

Patient Must Be Safeguarded

Thus, presence of a contagious disease or other circumstances may sometimes require that a person not be admitted after being given emergency care. Or, if the hospital does not have adequate facilities to continue treatment, transfer to another hospital may result in better care for the patient. Such decisions must be based on the special circumstances of each case and the hospital should be certain in all cases that it is considering the best interest of the patient.

A hospital runs considerable legal risk if it fails to use due care to safeguard the patient when it decides to cease treatment altogether, or to transfer the patient to another institution. This is especially true when the decision to transfer is based on the patient's inability to pay for care, or upon the fact that the patient is of a race or religion which the hospital prefers not to admit.

(*Continued on Page* 152)

John F. Horty is director of the Health Law Center at the University of Pittsburgh. This is the concluding article of a series dealing with emergency care. The series started in the February issue.

Money, the channels of communication, and ability to exert leadership may be more important in determining who has power in the hospital than any organization chart

The Politics of Power in a Hospital

Richard T. Viguers

Only the uninitiated believe that the organization chart shows where the power actually lies in a specific hospital. While the real power structure varies from hospital to hospital, it seldom follows the organization chart. If you want to get a decision made in Hospital A you might go to one member of the board of trustees; in Hospital B you might go to a member of the medical staff; in Hospital C it might be the administrator who has the power, and in Hospital D it might be some other person.

Power in a hospital means the ability to make or influence important decisions.

What forces cause the power structure in a hospital to deviate from the organization chart? Politics has been defined as the "science of how who gets what, when and why."[1] So the question might be phrased: What are the *politics* of the deviation in the power structure from the organization chart? *(Continued on Next Page)*

Mr. Viguers is administrator of Pratt Diagnostic Clinic, New England Center Hospital, Boston.

[1]Hillman, Sidney: Political Primer for All Americans, 1944.

CONTROL OF STRATEGIC RESOURCES – Money makes the world go round

Financial Resources. When one person provides a strategic amount of money for the hospital, that person tends to acquire power in the hospital.

Suppose the Happy Hollow Hospital, after all contributions have been received and income from endowment applied, has a $50,000 deficit. The board of trustees then turns to its devoted member, Mr. Larson, who generously gives the necessary $50,000 to the hospital. If he wishes to exercise it, Mr. Larson tends to have power in this hospital structure because of his control of a strategic resource.

In a similar financial situation if the money is obtained from old Mrs. Jones and the hospital administrator is the only one who is successful in persuading her to make this large and strategic annual contribution, here the administrator tends to have power because of *his* control of a strategic resource. Or if old Mrs. Jones is a patient of Dr. Allen's, and Dr. Allen was the one who was able to get her to give the $50,000 every year, then Dr. Allen tends to have the power in the hospital.

Power in the hospital may also be derived from control of a strategic part of the hospital income. Assume that in the community there are two hospitals, the Happy Hollow and the Mountain View. On the staff of the Happy Hollow Hospital is Dr. Cannon, the leading surgeon in the community, a very busy man who usually has about 15 patients in that hospital. On the recommendation of the administrator, the board of the Happy Hollow Hospital is considering the appointment of a full-time radiologist to replace Dr. Dalton, who as a general practitioner associated with Dr. Cannon has been doing the radiology on a part-time basis.

If Dr. Cannon should say that if the new radiologist is appointed he will take all his patients to the Mountain View Hospital, it is unlikely that the new radiologist will be appointed. This is not because losing 15 patients would create an insuperable deficit at Happy Hollow Hospital, but because Dr. Cannon as an outstanding surgeon is best qualified to judge the competency of the radiologist, and the board can be expected to follow this professional recommendation.

Medical Resources. The most important resource of a hospital is its medical staff, and the control of this resource by a single individual tends to give him important power.

Suppose the Happy Hollow Hospital needs several more general practitioners on its staff. Continued efforts by the board, the administrator, and the medical staff have failed to find a single doctor to fill these vacancies. Then Dr. Baker, a member of the medical staff, because of his wide contacts and personal charm, is able to interest two doctors in coming and practicing in the community. The control of this strategic resource puts Dr. Baker in a position of power. It is easy for Dr. Baker to say, "In order to get these doctors to come to this community you will have to do these things. . . ."

POWER THROUGH CONTROL OF COMMUNICATIONS

If you are in the know, you can make your empire grow

If the administrator is the sole channel of communication between the board of trustees on the one hand and the medical staff and hospital employes on the other, the administrator tends to have power.

Suppose that in the Happy Hollow Hospital the administrator is the one channel of communication between the medical staff and the board of trustees, and the medical staff has recommended that the hospital buy a super-

electronic wigglewaggoner for $10,000. In raising the question with the board of trustees, the administrator might report:

"The staff wants to spend $10,000 for a super-electronic wigglewaggoner. This is a piece of fancy equipment which probably will never be used. It will produce no income for the hospital; we can't buy every gadget that some doctor sees at a medical convention."

In this event the trustees are likely to decide against the purchase.

On the other hand, the administrator could report:

"The medical staff has carefully reviewed the purchase of a super-electronic wigglewaggoner and unanimously recommends the purchase of this equipment. This is not used very often but when it is needed it may save a life, and it may be your life. This is the kind of modern equipment which we must have if we are to be a progressive hospital and adequately serve the community."

Then it is likely that the trustees will react favorably to the purchase.

The power derived from control of communication between the board and the medical staff is obvious, and it is for this reason that medical organizations insist on another channel going directly from the medical staff to the board. This channel may be provided by a liaison committee, by having a member of the medical staff attend board meetings, or by other arrangements that enable the staff to by-pass the administrator.

If the administrator does not attend meetings of the board of trustees, or even if he attends and does not communicate effectively to the board, then the administrator tends to lack power. If communication between the hospital and the board is by way of informal channels through some other individual, then that individual has power. This individual might be a trustee who visits the hospital and talks to employes and doctors, or it might be a doctor who meets trustees informally and advises them of what is going on at the hospital.

President Kennedy is reported to have asked a scholar from an Eastern university to advise him on certain problems. A few days earlier, the President had asked another man whose background was more practical than theoretical to do the same job. Knowing this, the scholar asked President Kennedy how the two should relate. The categorical answer was, "Don't. I simply cannot afford to have just one set of advisers." The scholar, in full agreement

We Are Concerned Here With How Power Is Gained

In the accompanying discussion of the politics of hospital power there is no implication intended as to whether power is used for good or evil. We are concerned with how power is gained, not what is done with it. However, it seems fair to assume that, by and large, power in the hospital is used for socially desirable ends. Since our hospitals in general are dedicated to community service and render a high standard of medical care in an efficient and economical manner, then it follows that the individuals in the hospitals having power have used the power for desirable ends.

and approval, later commented, "If a president has only one set of advisers, the advisers take over the presidency."

The administrator who controls communications among the hospital, the medical staff, and the trustees has power, but if the administrator has just one adviser in the hospital, then that adviser tends to take over the administration.

It has been said that "secretaries run the world." Whether they run the world or not, they do sometimes run a hospital. This power in the secretary arises from her control of communications and her ability to communicate more effectively with the boss. The effect of a carefully thought-out memorandum from Mr. Mellon, the purchasing agent, may be completely demolished by a secretary's casual remark, "Well I see that Mr. Mellon is trying to do some empire building again."

In most organizations you will find the "fair haired lad" or the court favorite. He is the heir apparent, has the inside track, and because of this special position and superior communication tends to have power in the organization — power which is unrelated to his formal position. The "assistant to" or the resident in hospital administration may have power of this sort.

Communication Must Be Effective. When we talk about power through communications we are implying effective communication. There must be "hearing" as well as "talking."

If Mr. Bailey, the president of the Mountain View Hospital, is a manager of the local insurance company and, with his primary interest in business, thinks that the hospital should be run on a businesslike basis and that the administrator is a good sound businessman; if in addition Mr. Bailey thinks that all doctors are not very practical in their ideas, then it is likely that Mr. Bailey will not "hear" recommendations made to him by members of the medical staff. On the other hand, he is likely to "hear" the recommendations of the good businessman — the administrator.

Effective communication, the ability to get ideas across to the board, the medical staff, department heads, and employes, is a key source of power in a hospital. The individual in the hospital organization — the administrator, a doctor, one of the trustees — who is able to sell his ideas effectively, tends to have power. In view of this it is somewhat surprising that most administrators spend relatively little time in the preparation of reports and recommendations to the board of trustees or other groups within the hospital. Many walk into a meeting and try to make their reports up as they go along. As a result, they lose an opportunity of gaining power in the organization.

DISTORTION OF ORGANIZATION

Things are not what they seem

Where a single trustee (or a small group of trustees) becomes particularly active — either because the trustee needs something to do or because the hospital needs leadership — this trustee tends to usurp both the powers of the board of trustees and the executive responsibilities of the administrator.

If some trustee has a desk in the hospital, or even if he visits the hospital weekly for a lengthy conference with the administrator, it is usually a sign that the trustee has power and is exercising it.

Caucuses. Power can also be obtained by caucus of a core group.

This happens when a small group of trustees or doctors or any other group gets together prior to a meeting, decides on how it will act on various items to be brought up, and then goes into the meeting with the decisions already made. Various groups may try to play this game when any important issue is coming up. It is not unusual for the administrator to caucus, in person or by phone, with individual trustees or small groups of trustees "to get the benefit of their advice" on some matter before a meeting. Similarly, members of the medical staff or other individuals may try to do the same thing. This political activity is based on the old adage that once a man's mind is made up it's hard to change.

Gerrymandering. Gerrymandering in a hospital is carving up responsibilities so as to take executive responsibility from the administrator.

This is done by the trustees where they wish to retain direct executive, as well as policy, responsibility, either because they feel that they can run the hospital better than the administrator or because the administrator has been so ineffective that the trustees have to take over the administrative function. Gerrymandering is usually done by

Power Seldom Pays Attention to the Organization Chart

The actual power in any hospital, the ability to make or influence important decisions, seldom follows the organizational chart. The politics of deviation from the organization chart may relate to control of strategic resources, control of communications, distortion of the hospital organization or effective leadership.

assigning the administrator responsibility for the housekeeping and hotel functions only. A business manager is appointed to be responsible for the financial aspects of the hospital, reporting directly to the treasurer.

In all professional and medical aspects, the medical staff reports directly to the board of trustees, often through a member of the medical staff attending board meetings. Thus by gerrymandering hospital responsibilities the trustees effectively become not only the board but also the executives of the hospital as well. This can also be accomplished by appointing a large number of trustee committees to cover every hospital function in detail. These committees tend to take over executive functions and by-pass the administrator in reporting their activities to the board.

Status Quo. The crystallizing of the hospital organization into a bureaucracy with an excessive amount of red tape is a favorite gambit to maintain the power in a *status quo* position.

When a hospital organization becomes bureaucratic it tends to withhold power from any group desiring change. It tends to give power to make "no" decisions and withhold power to make "yes" decisions. A "no" decision seldom opens the administrator or others to immediate serious criticism, but a total "no" policy inevitably leads to hospital deterioration, and ultimately to a revolutionary change in the hospital power structure.

Committee Politics. Committee politics obviously play an important part in the power politics in the hospital. Examples:

A committee will not ordinarily make a decision which will adversely affect the interest of a member of the committee unless there is a clear and present danger to the majority of the group. For example, the medical staff will seldom vote against a member of the staff.

A committee also tends to take the point of view of the appointing authority. Thus a committee of doctors appointed by the medical staff to review the plans for an addition to the hospital will take a completely different point of view from a committee of the same doctors appointed by the trustees.

Committees seldom make decisions which are not unanimous. If members of a committee have no strong feelings about a matter they will usually vote for the motion. (Obviously, you always aim to get the motion made the way you want it!) The later an item is on the agenda the less chance there will be of a full discussion and the more chance that it can be pushed through.

The larger the committee the less likelihood that constructive discussion will take place and the more that snap decisions will be made based on irrelevant or emotional arguments. But it should also be remembered that the more people involved in making a decision the more likely it is that the decision can be carried out.

Who supports the administrator?

While the board of trustees gives the administrator the

formal symbol of authority and power when it appoints him, the board seldom supports the administrator when he needs support. The board will pass the formal resolutions and votes, but when it comes to taking action to enforce compliance, it will usually seek to avoid the issue.

The general and quite reasonable point of view of the board of trustees is that it wants an administrator who can accomplish things and run the hospital without requiring support from the board. When the administrator has to go to the board to ask for support he is indicating his own ineffectiveness, and in most such situations the board will not support him even if he is being criticized for carrying out board policies.

Can the administrator look to the general public, the people of the community, for support? If the administrator has done an effective and successful job in running the hospital over a period of years, one might think that the community would support him, but this is seldom the case. The community is not organized for any effective action and is usually not close enough to the situation to know what is going on. Only in rare cases can the administrator look to the community for support.

What about the hospital employes? If the administrator is well liked, the morale is high, and the employes believe the hospital has been well administered, the employes can give some support, but it is usually not effective. The employes are not organized, they do not have any good lines of communication to the board, and there is a natural hesitancy to become involved in an argument which might adversely affect an employe's own job. So hospital employes cannot be expected to give the administrator support in a strategic situation.

This leaves one other group — the medical staff. The medical staff *is* effectively organized and usually has good channels of communication to the board of trustees. It consists of men who are generally respected in the community, and who know how to present their position. This group can be the main support of the administrator, and when the medical staff withdraws its support the administrator almost inevitably loses. It is paradoxical that the administrator must require the staff to comply with onerous and troublesome regulations regarding such matters as medical records and use of operating rooms. As one analyzes the various groups, it appears that the administrator of the hospital must depend on the medical staff for his strategic support, and when he loses this support he usually must resign.

There is a tendency to think that power comes as a result of fortuitous, external circumstances — for example, through the possession of wealth. But, observing the scene objectively, one is impressed by the number of situations where power is obtained because an individual has the ability to meet a need in leading the organization toward a desired goal. Usually two factors must be present; each amounts to little without the other, and yet neither can create the other.

First is the need within the organization for a certain type of leadership to achieve a desired goal. Second is a leader who can fulfill these needs. The special circumstances of World War II called Sir Winston Churchill to power, and he had the qualities and abilities to meet the needs. If the time had been one of peace and prosperity Sir Winston probably would not have become prime minister. In "The Admirable Crichton" the family butler changes roles and becomes the "governor" when the family is wrecked on a desert island; later, when the family is rescued and returns to civilization, he reverts to the butler's position.

While the "trait theory" of leadership has fallen into disrepute, there are nevertheless particular situations in which the man with the necessary qualities rises to power in the organization.

EFFECTIVE LEADERSHIP

Success Breeds Power

Expertness or "expertise" as Robert Presthus calls it,[2] is one type of leadership ability. Among a group in a lifeboat adrift at sea, the expert seaman tends to obtain power. In a scientific organization, the person with great scientific ability tends to have power.

But power must always be in terms of the needs of the organization. In the Happy Hollow Hospital there is a dishwasher, Mr. Pavoloski, who has an excellent voice of concert quality, while the administrator of the hospital couldn't carry a tune in a basket. In the operation of the hospital the administrator has the power, but when a group assembles to sing, Mr. Pavoloski has the power and the administrator becomes low man on the totem pole.

It is common for the person with special leadership talent to meet particular needs to be given the formal position of power, but this is not always true. However, the leader will have power even without the formal symbols of power.

It should also be noted that success breeds power. If the hospital has been successful, the public is pleased, employe morale is good, the medical staff is satisfied, and the financing adequate — then the administrator tends to have power.

This success of the hospital is not necessarily the result of good administration. It may be in spite of the administrator just as much as because of the administrator, but whether or not he is responsible, success tends to give him power. It is equally true that if the hospital is not operating successfully the power of the administrator tends to be weakened, regardless of whether or not the responsibility for the failure was his. ■

[2]Presthus, Robert V.: Authority in Organizations, Public Administration Review, 20:86 (Spring) 1960. Prof. Presthus gives a scholarly and valuable discussion of the legitimization of authority.

Small Specialized Bed Units Lower Occupancy

Higher occupancy can be achieved by reducing the number of small separate pediatric and obstetric units and developing greater flexibility in the use of beds, this study of 14 Pennsylvania hospitals indicates

Morris London and Robert M. Sigmond

DESPITE an apparent abundance of empty beds, some persons are still being placed on hospital waiting lists. The trouble is that the right kind of bed is not always available in the right hospital at the right time.

Many of the 150,000 nonfederal general hospital beds that were empty on a typical day last year were on specialized nursing units and were not interchangeable in use.

An empty bed in an obstetrical unit of Hospital A is of little use to a surgical patient whose surgeon is on the staffs of Hospitals B and C.

Specialization of nursing units in general hospitals is related to licensing requirements, tradition, desires of medical specialists or medical or nurse educators, physical design of buildings, age, sex and pay status of patients, and other factors. Whatever the merits of specialization of nursing units, one effect is to depress bed occupancy rates.

Specialized bed units characteristically have proportionately greater day-to-day variation in admissions, discharges and census than do less specialized units, especially when the number of admissions is not large. Specialized units must maintain more beds to meet peaks in census, which results in relatively lower occupancy. The general practice of providing segregated maternity and pediatric units – and in some cases separate medical or surgical units – is one of the most important factors holding down bed occupancy rates.

This article, the second in a three-part series describing the hospital bed occupancy study of the Hospital Council of Western Pennsylvania, will focus on obstetrics and pediatrics in order to illustrate how segregated services affect hospital occupancy. Eleven of the 14 short-term general hospitals in the study maintained separate pediatric and maternity sections, in addition to medical-surgical services (see Table 1). Six of these hospitals had over-all occupancy of 80 per cent or below; five had occupancy above 80 per cent. The experience of these 11 hospitals during a four-month period may be summarized as follows:

– Occupancy of each of the pediatric and maternity units was less than 80 per cent, although medical-surgical occupancy was at least 80 per cent in every hospital, as shown in Table 1 on the next page.

– More than one-third of the total pediatric and maternity beds were empty on the average day, although about half of the hospitals were full on pediatrics or obstetrics for at least some days during the study.

– One-quarter of all of the pediatric

Morris London is assistant director, Jefferson Medical College Hospital, Philadelphia. At the time the article was written, Mr. London was research associate, Hospital Council of Western Pennsylvania, Pittsburgh. Robert M. Sigmond is executive director of the Hospital Council of Western Pennsylvania.

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This is the second in a series of articles which present some preliminary findings and conclusions from the Hospital Bed Occupancy Study now being conducted by the Hospital Council of Western Pennsylvania. The first article in this series, "Are We Building Too Many Hospital Beds?" appeared in the January issue of this magazine.

Fourteen general hospitals which are participating in the study have supplied daily census reports for a full year. The census data, supplemented by a review of administrative practices and procedures in all of the hospitals, provide the basic information for the project. The occupancy statistics discussed in these articles cover the first four months of the study (121 calendar days).

Data presented in the first article indicate that hospitals with relatively high occupancy rates have a smaller proportion of beds constantly empty than the hospitals with relatively low occupancy, and are more successful in controlling variations in demand for hospital care. A tentative conclusion is that a significant increase in occupancy can be achieved in some hospitals by closing beds, temporarily or permanently, and converting badly needed space to other uses. Another preliminary finding suggests that neighboring hospitals which serve some of the same physicians might be able to shut down beds and increase bed occupancy by coordinating the activities of admitting offices.

The emphasis in the first article was on analyzing over-all occupancy or its counterpart, total vacancy. However, over-all occupancy is an average statistic that is determined by each of the major clinical services or departments. In this second article, occupancy on medical and surgical, obstetric and pediatric units is analyzed in detail in order to pinpoint their relative effects on over-all occupancy. It will be seen that inability to control occupancy on obstetric and pediatric units is a major reason why many general hospitals are unable to attain higher levels of over-all occupancy.

Small segregated units are necessarily inefficient, the bed occupancy findings suggest, and should be eliminated or modified

TABLE 1 — VARIATION IN OCCUPANCY RATES ACCORDING TO SERVICE IN 14 VOLUNTARY GENERAL HOSPITALS NOV. 1, 1959, TO FEB. 29, 1960

Hospital	Total Beds	Over-All Occupancy Rate	Occupancy by Service		
			Medical-Surgical	Obstetric	Pediatric
A	244	74	80	66	48
B	198	75	81	55	66
C	329	76	84	48	50
D	264	79	88	53	61
E	337	79	85	57	71
F	216	80	84	79	56
H	225	82	83	74	63
J	380	86	91	77	52
K	278	88	96	56	63
L	313	89	96	60	60
M	312	91	96	74	79
Total 11 hospitals*	3096	82	88	63	62
G	350	80	79	82	—
I	383	86	86	—	—
N	164	91	94	82	—
Total group	3993	83	88	69	62

Information for all tables accompanying this article is for the period from Nov. 1, 1959, to Feb. 29, 1960. The identifying code letter for each hospital remains the same in all tables.
*Hospitals having all three units — medical-surgical, obstetric and pediatric.

In each of 11 hospitals with separate pediatric and obstetric units, occupancy of each of these units was less than 80 per cent. Medical-surgical occupancy was 80 per cent or more in every hospital. Hospitals not having all three units are shown at the bottom of table.

beds and one-fifth of all of the maternity beds were empty *every single day during the study.*

— Although about a quarter of the bed complement was in pediatrics and maternity, these services accounted for almost half of the total vacant bed days.

These and other findings obtained in the bed occupancy study suggest that small segregated bed units — such as pediatrics and obstetrics — are necessarily inefficient and should be eliminated or modified whenever the need can be met effectively in other ways.

Pediatric Occupancy

Three of the study hospitals did not maintain pediatric units. One admitted children to a few rooms set aside on a medical-surgical floor. Two were affiliated with a near-by children's hospital and did not admit children. In the remaining 11 hospitals, pediatric units ranged from 15 to 40 beds; the median was 28 (see Table 2). Average daily census ranged from 10 to 31; the median was 17. The volume of pediatric days at most of these hospitals was less than 10 per cent of total patient days. The average pediatric census was so small that day-to-day variability created peaks about 50 per cent above average census.

Occupancy ranged from 48 to 79 per cent (62 per cent average). Six hospitals had a constant vacancy rate[1] of zero; that is, all beds were full on one or more days during the study period. Two other hospitals showed a small constant vacancy rate — one bed unoccupied on the peak census day. Constant vacancy exceeded 10 per cent in only 3 hospitals.

Despite the low occupancy rates, these data suggest that individual pediatric units were not excessively large. Because of the relatively small pediatric demand met by each hospital, daily demand upon each varied widely. Beds that went frequently unoccupied had to be maintained to meet peaks in demand. Variable va-

[1]*Constant vacancy rate* is the percentage of a hospital's total bed complement that is unoccupied every single day. It is computed most simply by subtracting the highest daily census from the total bed complement, multiplying by 100, and dividing by the total bed complement.

TABLE 2 — CONSTANT AND VARIABLE VACANCY RATES ON PEDIATRICS IN 11 VOLUNTARY GENERAL HOSPITALS

Hospital	Number of Beds	Occupancy	Vacancy Rates		
			Constant	Variable	Total
A	29	48	17	35	52
C	21	50	0	50	50
J	32	52	25	23	48
F	23	56	4	40	44
L	24	60	0	40	40
D	30	61	3	36	39
K	28	63	14	23	37
H	15	63	0	37	37
B	23	66	0	34	34
E	32	71	0	29	29
M	40	79	0	21	21
Total group	297	62	25	13	38

Hospitals G, I and N did not maintain pediatric units.

The hospitals maintaining separate pediatric and maternity beds had occupancy rates ranging from 48 to 79 per cent. More than half, however, were full on one or more days during the study. Small demand met by each hospital made it hard to stabilize occupancy.

cancy rates[2] ranged from 21 to 50 per cent.

Accordingly, any attempt by a hospital to increase occupancy by closing pediatric beds would require major efforts to control variability in demand. Shaving the bed complement of the pediatrics departments of the study hospitals by even as much as 20 per cent (three to eight beds) would not have a significant effect on operating expenses and efficiency. In addition, the space saved could hardly be used effectively.

Tentative Conclusion: Small independent pediatric units cannot be expected to function effectively at high levels of occupancy. Although it is possible to increase the occupancy rate by closing part of the pediatric complement, such an approach does not appear to offer tangible results.

Even though constant vacancy on individual pediatric units was small or nonexistent, constant vacancy accounted for two-thirds of the total vacancy rate of the 11 units *considered as a group* (see Table 2). In fact, on no single day were more than three-quarters of the total 297 pediatric beds filled. The 75 constantly vacant pediatric beds exceeded the total complement of the two largest units combined. Clearly, too many pediatric beds existed in relation to demand on the *group* of hospitals.

[2] *Variable vacancy rate* represents the average percentage of bed complement that is sometimes vacant, exclusive of those beds that are continuously unoccupied. It is computed most simply by subtracting the constant vacancy rate from the total vacancy rate.

Further information on computing these rates can be found in "How To Compute the Rate of Vacancy," Mod. Hosp. 96:62 (January) 1961.

Tentative Conclusion: Increase in effective utilization of a community's pediatric beds can be achieved by cooperative action among hospitals to permit closing some entire units.

Reduction in the number of separate pediatric units would assure the operation of larger services with proportionately lower peaks in census. If, for example, the average pediatric census of 184 and peak census of 222 registered at the 11 hospitals during the 121 day study period had been grouped at a single hospital, an occupancy rate of 83 per cent could have been achieved in a 222 bed unit, without any waiting list. Grouping the pediatric services of any two or more hospitals at one location enables the merged unit to meet combined demand with fewer beds. Not only is valuable space saved by grouping; in addition, there should be either substantial reduction in operating cost, improvement in quality of care, or both. Educational experiences for nursing students and house staff likewise could be enriched through affiliations with hospitals having larger services.

Concentrating pediatric services in fewer hospitals presents complex problems involving interchange of medical staff appointments and coordination of teaching programs for nurses and interns. The apparent advantages, however, justify efforts in this direction.

Our study indicates other alternatives that merit widespread exploration. For example, in some hospitals pediatrics is located adjacent to a general nursing unit. If the design of the entire floor is suitable, only minor physical alterations may be needed to set up an "accordion" type of pediatric unit that permits a reduction in bed complement. The number of beds assigned to children is varied as demand requires. Two hospitals in the study group had the opportunity to adopt such an approach.

In some situations, it may be possible for a hospital to relocate its separate pediatric unit and admit children to a specific section of a general nursing unit. By varying the

TABLE 3 — CONSTANT AND VARIABLE VACANCY RATES ON OBSTETRICS IN 13 VOLUNTARY GENERAL HOSPITALS

Hospital	Number of Beds	Occupancy	Vacancy Rates		
			Constant	Variable	Total
C	39	48	13	39	52
D	47	53	21	26	47
B	33	55	18	27	45
K	34	56	15	29	44
E	46	57	13	30	43
L	36	60	11	29	40
A	37	66	3	31	34
M	44	74	0	26	26
H	26	74	0	26	26
J	42	77	0	23	23
F	40	79	0	21	21
N	30	82	0	18	18
G	146	82	1	17	18
Total group	600	69	20	11	31

Hospital I did not maintain an obstetric unit.

Maternity services were usually 10 to 12 beds larger than pediatric services. The average occupancy for obstetric units was higher than the average for pediatric units. For the hospitals as a group, one-fifth of all maternity beds were empty every day during the study.

allocation of beds to the section in relation to pediatric demand, more effective utilization of the entire nursing unit is possible. Provision of concentrated pediatric nursing care, maximum physical flexibility, and adequate isolation facilities are prerequisites of this practice. One hospital in the study group which did not maintain a separate pediatric unit set aside a few specific rooms on a medical-surgical floor for children.

Even where segregated units are maintained, children are not necessarily limited to pediatrics. Hospitals in the study group generally admitted children up to 12 or 13 years old to pediatrics, although mature children above average size could be admitted to other units. Most hospitals sometimes admitted children to other floors when desired accommodations were not available on pediatrics. A few hospitals admitted 15 or 16 year-olds to pediatrics. There was latitude, therefore, in the section of the hospital where a child could receive treatment.

Maternity Occupancy

Only one of the 14 study hospitals did not maintain an obstetric unit and it is affiliated with another study hospital with 146 maternity beds, one of the largest such services in the country. The number of maternity beds in the other 12 hospitals ranged from 26 to 47; the median was 38 (see Table 3). Average daily census ranged from 18 to 32; the median was 25. Generally, the maternity services were 10 to 12 beds larger than pediatric services. Obstetric beds were largely housed on a single nursing unit.

As was the case with the pediatrics department, the demand for maternity beds in individual hospitals was so small that peak census days exceeded average census by about 50 per cent. Proportionate variation in census was less in maternity than in pediatrics, presumably because of the larger size of the maternity units and because there is less daily fluctuations in births than in pediatric illness. Variable vacancy rates among the 13 hospitals ranged from 17 to 39 per cent; median was 26 per cent.

The hospital with 146 maternity beds filled the largest obstetric demand and showed the lowest variable vacancy rate, 17 per cent. Its constant vacancy rate was 1 per cent, indicating a few beds empty throughout the study period. This large maternity service operated at an average occupancy rate of 82 per cent, met all demand, and still had beds at any time for an emergency.

Another hospital with 30 maternity beds operated at more than 80 per cent occupancy. It was designed to admit obstetric patients to one end of an adjoining surgical unit when demand exceeded the capacity of the maternity unit.

Four hospitals, with maternity units varying from 26 to 44 beds, had occupancy rates ranging from 74 to 79 per cent. Each unit had a constant vacancy of zero, indicating no unoccupied beds for at least part of the study period. Serious problems face any hospital when it has no maternity vacancies since obstetric cases must be segregated by state licensing requirements and admission cannot be delayed. However, practices such as direct admission to labor rooms and transfer to other floors of mothers who have lost babies made it possible to admit additional patients at peak census periods.

Seven hospitals had obstetric occupancy rates between 48 and 66. All except one had constant vacancy rates of at least 10 per cent; all had variable vacancy of at least 26 per cent. Among these "low occupancy" services, daily occupancy averaged

TABLE 4 — CONSTANT AND VARIABLE VACANCY RATES ON MEDICAL-SURGICAL IN 14 VOLUNTARY GENERAL HOSPITALS

Hospital	Number of Beds	Occupancy	Vacancy Rates		
			Constant	Variable	Total
G	204	79	0	21	21
A	178	80	2	18	20
B	142	81	0	19	19
H	165	83	1	16	17
C	255	84	0	16	16
F	153	84	0	16	16
E	259	85	2	13	15
I	383	86	5	9	14
D	187	88	0	12	12
J	272	91	0	9	9
N	134	94	0	6	6
K	216	96	0	4	4
M	228	96	0	4	4
L	253	96	0	4	4
Total group	3,029	88	4	8	12

Hospitals in the survey reported that 4 per cent of medical-surgical beds (121) were vacant every day of the study. In 10 hospitals all of these beds were occupied at least one day during the study. However, variability is more controllable here than on pediatrics and obstetrics.

60 per cent or less on 75 of the 121 calendar days studied. These seven services with a total of 272 maternity beds provided less than a third more obstetric days than did the one hospital with 146 maternity beds.

For the 13 hospitals *as a group*, one-fifth of all the maternity beds (120) were empty every day during the study period. As in pediatrics, constant vacancy was a more important factor for the group as a whole than for any of the individual hospitals.

Tentative Conclusion: Small independent maternity units cannot be expected to function effectively at high occupancy levels and should be closed wherever possible. Good results are obtainable from an "accordion" type of maternity unit, which can be expanded or contracted as needed, with resulting changes in the bed complement of an adjoining general nursing unit. Nevertheless, most effective utilization of maternity beds in an area would be ensured by cooperative arrangements among hospitals to reduce the number of separate units and concentrate larger units in fewer hospitals.

Development of the flexible "accordion" type of unit may be impossible in many hospitals because the obstetric service is located in an independent wing or on a separate floor. In some cases, renovation or new construction can overcome this physical handicap. Prime consideration should be given to traffic flow patterns and suitable location of nurseries, utility rooms, nursing stations, and elevators.

Admitting certain types of gynecology patients to obstetrics is often suggested to achieve better maternity bed utilization. This practice was not found in the study hospitals because of Pennsylvania licensing requirements. Several research projects to explore this approach are reported under way. If these projects demonstrate that other patients can be safely admitted to maternity floors, census fluctuations might be decreased appreciably. However, changes in licensing regulations and modification of medical and hospital attitudes would be required in overcoming the traditional isolation of obstetric units. Regardless of these developments, in an area with a number of general hospitals in close proximity, fewer and larger maternity services appear to be in the public interest.

The American College of Obstetricians and Gynecologists has recommended that the annual rate of occupancy in maternity should not exceed 70 to 75 per cent because of wide census fluctuations which occur.[3] This recommendation appears to be realistic for small inflexible units. Larger and more flexible maternity units should be able to operate efficiently at 80 per cent occupancy or higher without lowering quality of care.

Medical-Surgical Occupancy

Each of the 14 study hospitals maintained three or more nursing units for general medical and surgical patients. One hospital had 383 medical-surgical beds and an average census of 328. The services in the other 13 hospitals ranged in size from 142 to 272; the median was 204. Average daily census for these 13 hospitals ranged from 115 to 248; the median was 164. Medical-surgical beds tended to be three times the number reserved for all other services combined.

Variation in medical-surgical demand at each hospital was much less than on pediatrics and obstetrics because of the larger size of the medical-surgical services and the substantial proportion of "elective" admissions which can be scheduled. As a

[3]Manual of Standards in Obstetric-Gynecologic Practice, March 1959, p. 5.

result, fewer medical-surgical beds were required in relation to average daily census, and occupancy was much higher.

Four hospitals had some constant vacancy on their medical-surgical units (see Table 4). In the other 10, all medical-surgical beds were occupied for at least one day during the four months under study. The hospital with the highest constant vacancy rate had 19 beds continuously vacant.

Variation in census accounted for almost all the total vacancy rates on medical-surgical services. Variable vacancy among the 14 hospitals ranged from 4 to 21 per cent. The median was 13 per cent compared with 26 per cent in maternity and 35 per cent in pediatrics. Variability in demand is more subject to control on these services than on pediatrics and obstetrics. Six hospitals held variable vacancy in medical-surgical services below 10 per cent. The three hospitals with the highest occupancy had variable vacancy rates of only 4 per cent.

Tentative Conclusion: Any hospital in which the medical-surgical vacancy rate exceeds 10 per cent should explore means of reducing the number of beds in use. Medical-surgical services should be able to operate at 90 per cent occupancy or higher.

In most hospitals, the basic approach to higher medical-surgical occupancy is stabilization of daily census fluctuations. This is dependent on avoidance of rigid assignment of medical-surgical beds by pay status, sex or clinical specialty; equitable waiting list management, and coordination of admissions among hospitals. If the variations in census are reduced, excess beds can be closed.

Existing design of nursing units and physical facilities often determines the extent to which beds are interchangeable. For example, in some of the study hospitals, units with central toilet facilities were necessarily restricted to either male or female patients. Renovation programs to achieve more flexible units and convert large wards to small bed units can aid greatly in stabilizing daily census, thereby relating the number of beds more closely to present demand and allowing the same volume of service with fewer beds.

Although 10 hospitals had no constant vacancy in medical-surgical beds, for the 14 hospitals *as a group*, 4 per cent (121) of these beds were vacant every day throughout the four-month study period. The actual number of constantly vacant beds on medicine and surgery was greater than that on pediatrics and approximately equal to that on maternity. While the problem of vacancies appears to center largely in pediatrics and maternity, as much opportunity to close excess beds exists in medical-surgical units. In some hospitals, higher occupancy can be achieved more easily and with fewer problems through reducing bed complement on medical-surgical units because inactivation of a single nursing unit can be accomplished without eliminating a separate service. ■

How Bed Occupancy Relates to Census

Occupancy rate, as is well known, is determined by the relationship between the average daily census and the bed complement. Viewed another way, the occupancy rate is determined by the relationship between the average daily census and the peak daily census that the hospital is prepared to serve. If the ratio of the expected peak census day to the average daily census can be reduced, it would be possible to close beds, thereby increasing the occupancy rate. The key to increase in bed occupancy is reduction in daily variations in inpatient service.

The studies of the Commission on Hospital Care showed that there is proportionately less daily *variation* in demand for inpatient service as the *volume* of demand grows larger. As a result, hospitals which serve larger population groups should be able to operate with proportionately fewer vacant beds than hospitals serving smaller population groups, *i.e.* they can meet the demand at higher levels of occupancy.

The Commission suggested that this relationship between variation and volume could be expressed in mathematical terms; that variation in demand is directly related to the square root of the average daily census. According to the Commission's formula, the *peak* daily census should rarely exceed the *average* daily census by more than three times the square root of the average daily census. For example, if demand is equivalent to an average daily census of 25, peak daily census would rarely exceed 40; a 40 bed unit with an occupancy rate of 62.5 per cent will meet the usual demand.

With an average daily census of 100, the peak demand can very likely be met with a bed unit of 130 operating at an occupancy rate of approximately 77 per cent. With an average daily census of 400, the peak demand can probably be met with a bed unit of 460, operating at an occupancy rate of approximately 87 per cent.

Accordingly, a smaller number of independent large units will necessarily require fewer beds to meet a population's demand and will operate at higher levels of occupancy than will a larger number of smaller bed units. To provide for an average daily census of 400 patients, approximately 640 beds will be needed if there are to be 16 independent locations of equal size; approximately 520 beds will be needed for four locations of equal size; and approximately 460 beds if the service is to be provided entirely at one location. ■

Emergency Units Inadequate, Study Shows

Two out of three hospitals surveyed reported that the physical plant of the emergency room was inadequate, and many emergency units lack such obvious aids as signs indicating the entrance

TWO out of three hospitals responding to a recent survey of emergency room care indicate that the physical plant of their present emergency unit is inadequate, and one-fifth reported that they lack so much as a sign to guide patients to the service. In 37 of the responding hospitals, the emergency department is not even accessible from the street.

These facts emerged from a study on all aspects of emergency room service made by Drs. Paul A. Skudder, James R. McCarroll, and Preston Wade of the New York Hospital-Cornell Medical Center.*

Of 330 short-term, nonfederal general hospitals queried, 286 answered the 90 question survey. Twenty-one of the hospitals stated that they had no emergency facilities, which left 265 in the sample group.

Studied Levels of Care

Purpose of the study, the authors explain, was to determine whether the charges leveled by many critics that the quality of emergency medical care has deteriorated have any foundation in fact, or whether the apparent deterioration results rather from the drastic expansion of the functions and responsibilities of hospital emergency service during the last 15 years.

The survey was based "on the physical plant and equipment of the emergency department and on the organization and staff in relation to the demands placed upon them, the premise being that deficiencies in these areas would probably reflect similar deficiencies in patient care and thus indirectly mirror the quality of medical care afforded by a given hospital," the report states.

All of the hospitals surveyed were requested to submit floor plans of the emergency department. From the plans submitted (by 70 per cent of the respondents) the authors compiled a list (see Table 1) of the basic physical components of an emergency department that most hospitals considered essential. They also studied the equipment, supplies and ancillary facilities deemed important in emergency room service (see Table 2). Not all of these items are kept in the emergency department, but they are available in the hospital, particularly in smaller hospitals where the supply area is accessible to the emergency department, the report of the survey indicated.

Although it is important, and quite simple, to post the location of all equipment and supplies in some central and readily visible area in the emergency room, one-quarter of all hospitals questioned replied that they had posted no such central list.

Two other simple, but important, procedures that would ensure smoother functioning of the emergency service, which are neglected by many of the respondent hospitals, are: (1) posting a roster of all physicians on call in the various specialties, and (2) preparing an emergency room manual outlining the services routinely rendered in the department.

Twenty-seven per cent of the hospitals questioned do not post a physicians' roster, and only one-third have prepared a manual. Many of these, it was pointed out, have neglected to include in the manual the location of vital equipment and supplies.

Only Half Truly 'Emergency'

While 71 per cent of the hospitals studied expressed the view that the emergency department should be restricted to the care of patients with actual emergency conditions, in practice, only half of the respondendents are able to restrict their care to true emergency patients; their emergency departments routinely perform such functions as caring for hospital personnel or serving as a general clinic. Inasmuch as many of the hospitals covered in this survey do not have an outpatient department, the emergency service is forced to assume additional functions.

In the light of the evidence that emergency facilities must meet demands for all types of medical service, the authors point out that supervision of an emergency service logically should be vested in a committee representing all clinical services, the hospital administration, and the nursing department.

Only one-third of the hospitals

*Skudder, Paul A., McCarroll, James R., and Wade, Preston A.: Hospital Emergency Facilities and Services, a Survey. Bulletin of the American College of Surgeons, 46:44 (March-April) 1961. This report was made by Dr. Skudder at a meeting of the Committee on Trauma in San Francisco, October 1960.

have such a committee, however, and in rural areas the percentage fell to 17 per cent. In only one-fifth of the hospitals was the direct professional responsibility for the supervision of the emergency department assigned to one individual. In the remaining hospitals, this responsibility was assumed by the chief of surgery or assigned on a rotating basis.

Relatively close supervision is exercised in regard to the activities of physicians who work in the emergency department, it was indicated. Only 31 of 114 urban hospitals permit general practitioners to practice in the emergency department without some restriction of their activities. In rural areas, however, only one-third of the hospitals restrict activities of general practitioners.

A series of questions on the clinical procedures routinely performed in the emergency area elicited the information that in more than half of the responding hospitals such major procedures as treatment of open fractures and the repair of tendon and nerve injuries are regularly carried out.

"For such major procedures, hospital emergency facilities designed primarily for minor surgical procedures can rarely substitute effectively for a regular hospital operating room," the authors comment. They add that "the widespread use of emergency facilities for nonemergent purposes can occur only at the expense of decreased efficiency in the care of actual emergencies."

Although the authors consider major operating facilities in emergency units "impractical and inefficient," they believe that a complete minor operating unit is an essential part of every emergency department.

"High standards of asepsis, lighting and equipment, and sterile technic should be rigorously maintained, and should include surgical preparation of operative fields and the use of sterile gloves and masks," they assert.

According to the survey, most hospitals indicate that they do adhere to these standards. One-third of the hospitals queried permit the administration of general anesthesia in the emergency room and three-fourths are prepared both physically and philosophically to perform thoracotomy and cardiac massage in the emergency room.

Some of the causes of poor public relations for hospitals deriving from their emergency room services were analyzed in the report. A major source of misunderstanding and irritation is the practice, followed by 88 per cent of the hospitals surveyed, of permitting attending physicians on call by the emergency department to submit bills to patients who come there for care and have no private physician. "Although such an arrangement seems equitable for the physician," the report states, "it may lead to misunderstanding by the patient, who may assume that the hospital charge covers all his professional care. This points up the need in emergency departments for brochures containing information for the public."

On this point of charges to patients, the report continues: "One-quarter of all hospitals permit physicians to bill patients whom they have not seen, following a telephone conversation with a house officer or nurse. This procedure is undoubtedly misunderstood by many patients and thus contributes to poor public relations."

Responsibility for emergency care does not rest entirely on the hospitals, according to the survey. Nearly half (43 per cent) of the hospitals surveyed stated that the medical profession through the local medical society or agency assumed some responsibility for providing emergency care, usually through a panel of physicians on call or an agreement for rotation on duty by the physicians of a community.

Such arrangements are not entirely successful, the authors point out.

Two-thirds of the 30 hospitals that

(*Continued on Page* 151)

Table 1—Basic Physical Components of Hospital Emergency Departments

1. Well illuminated entrance from street
2. Space for loading, unloading, and turning around of vehicles
3. Ramps and platforms for unloading patients
4. Registration area for incoming patients
5. Waiting room with toilet facilities, public telephones, adequate seating, and public information brochures
6. Patient examining units which can accommodate emergency equipment; and sufficient in number to accommodate the average patient load
7. Doctors' and nurses' station
8. Call room for doctors
9. Nearby x-ray facilities
10. Facilities for treatment of fractures
11. Minor surgery operating room facilities, including lighting and scrub sinks, operating table
12. Storage facilities for emergency equipment strategically located and conspicuously labeled
13. A hospital page or call system

The basic physical facilities and the supplies listed in these tables are considered essential for efficient operation of emergency services.

Table 2—Supplies for Emergency Use

Oral airways of all sizes
Pressure dressings
Surgical dressings of all sizes
Positive pressure resuscitation equipment
Intravenous equipment
Stomach tubes
Oxygen equipment
Suction equipment
Plasma or plasma expanders
Intravenous solutions
Splints
Tourniquets
Tracheotomy tubes
Wheel chairs
Stretchers
Litters
Crutches and canes
Chest suction equipment
Plaster of all sizes
Sphygmomanometers
Ophthalmoscopes
Otoscopes
Surgical suture equipment of good quality
Catheterization equipment
Pharmaceuticals for emergency use
Sterile gloves and drapes
Elastic bandages
Flashlights
Head mirrors
Nasal speculi
Sterile packing of all sizes
Syringes and needles of all sizes
Sterile irrigating solutions
Suture material of various sizes
Thermometers
Antidotes for specific poisons

Television receiver located over lobby door of Aultman Hospital's school of nursing enables attendant to view it and televised tunnel entrance at the same time.

Closed-Circuit TV Keeps an Eye on the Door

George R. Wren

CLOSED-CIRCUIT television can't quite enable one person to be in two places at the same time—but it does the next best thing at Aultman Hospital, Canton, Ohio.

The direct wire television installation, along with an apartment type of buzzer, makes it possible for one housemother to control two entrances to the hospital school of nursing, which are some distance from one another.

Like many hospitals, Aultman has a tunnel connecting it with the school for student nurses who must go back and forth at all hours, often alone. The tunnel itself, secluded from public scrutiny, presents a special security problem.

Formerly, after-hours coverage of both the tunnel, which is at basement level, and the front entrance meant that either two housemothers had to be employed or one would have to leave her post at the main entrance whenever a student rang the bell for entrance from the tunnel.

The closed-circuit camera, mounted inside the school of nursing within a wired cage to prevent anyone's tampering with it, is focused on the length of the tunnel and the area immediately outside the tunnel door.

Extra lighting was installed in the tunnel to facilitate the working of the camera. The receiving set is mounted in the lobby where it is easily visible from the housemother's desk.

Besides watching the screen to note any suspicious activity in the tunnel, the housemother can see who is at the door when one of the students comes over from the hospital through the tunnel and rings the bell for entrance.

When the housemother sees on the TV screen that it is a student nurse who is ringing she checks that the student has been on duty or on a valid late leave. She then presses the buzzer to establish an electrical contact that allows the student nurse to open the tunnel door and enter the school.

This closed-circuit installation, which cost less than $1000, has been in use for more than a year and has proved extremely successful. It permits the employment of only a single housemother and keeps her on duty at the front desk of the school while still permitting her to control the tunnel and the tunnel entrance. The comparatively low cost of this installation has suggested several other uses to us that we are studying. ■

Mr. Wren is director, Aultman Hospital, Canton, Ohio.

ABOUT PEOPLE

Administrators

Oliver E. Deehan has been named administrator of Palo Alto Stanford Hospital Center, Palo Alto, Calif. He succeeds **Dr. E. Dwight Barnett,** who resigned last June. Mr. Deehan received his master's degree in hospital administration from the School of Public Health and Administrative Medicine, Columbia University. He joined the Palo Alto hospital in 1957 as associate administrator and was promoted to deputy administrator in 1959.

Oliver E. Deehan

Dr. Ernest C. Shortliffe has been named executive director of the new Presbyterian-University Hospital of the University of Pittsburgh Health Center, Pittsburgh. Dr. Shortliffe has resigned his post as associate executive director of Hartford Hospital, Hartford, Conn., and will assume his new duties June 1. Dr. Shortliffe is a trustee of the Connecticut Hospital Association and chairman of the council of professional practice of that organization. He is also a director of the National League for Nursing and chairman of a committee on outpatient services of the American Hospital Association. **Thompson D. McCrossin,** present administrator at Presbyterian, is expected to remain with the new setup.

Dr. Ernest Shortliffe

Alvin Goldberg is the new administrator of Polk County Hospital, Bartow, Fla., succeeding **Walter Harrell.** Previously, he was assistant administrator of South Florida Baptist Hospital, Plant City. Mr. Goldberg is a graduate of Rutgers University's college of pharmacy and the Georgia State College course in hospital administration.

Eric Freeborn has been named administrator of Ross Memorial Hospital, Lindsay, Ont. He has been the acting administrator.

Dr. Robert J. Scott, manager of the V.A. hospital, Fort Wayne, Ind., has been appointed manager of the V.A. hospital at Richmond, Va. Dr. Scott will succeed **Dr. James E. Cottrell,** who is being transferred to the staff of the V.A. area medical director at Trenton, N.J.

Henry Veldman has been appointed director of the Sturdy Memorial Hospital, Attleboro, Mass., succeeding **Albert O. Davidsen.** Mr. Davidsen is now director of Christ Hospital, Jersey City, N.J. Mr. Veldman has a master's degree in hospital administration from the University of Chicago.

Harry C. F. Gifford has resigned as administrator, Community Hospital at Glen Cove, Glen Cove, N.Y., to become administrator, Springfield Hospital, Springfield, Mass. Mr. Gifford is a graduate of the School of Public Health and Administrative Medicine, Columbia University.

Dr. Joseph A. Mendelson, superintendent of Dayton State Hospital, Dayton, Ohio, will retire June 30. He has been head of the hospital since 1949.

William W. Peters has taken over duties as the new administrator of Monsour Hospital and Clinic, Inc., Jeanette, Pa. He formerly was assistant director of Methodist Hospital of Brooklyn, Brooklyn, N.Y. Mr. Peters has a master's degree in hospital administration from the University of Minnesota and is a member of the American College of Hospital Administrators. He succeeds **Silvio R. Lamattina** at Monsour.

Marcus E. Drewa has been named administrator of Knapp Memorial Methodist Hospital, Weslaco, Tex. He was formerly assistant administrator at Baptist Memorial Hospital, Kansas City, Mo. Mr. Drewa has a master's degree in hospital administration from Northwestern University. He served his administrative residency at Baptist Memorial Hospital, Jacksonville, Fla.

Marcus E. Drewa

William E. Murray, president of the Washington State Hospital Association, resigned as administrator of Olympic Memorial Hospital, Port Angeles, Wash. Succeeding Mr. Murray at Olympic Memorial is **Henry S. Rogers,** formerly administrator of Memorial Hospital, Sedro Woolley, Wash.

Dr. G. Lee Sandritter is the new superintendent and medical director of Atascadero State Hospital, Atascadero, Calif. He was previously superintendent of Eastern State Hospital, Medical Lake, Wash.

Col. A. M. Libasci, M.D., is the new administrator of Pima County General Hospital, Tucson, Ariz., succeeding **Dr. Francis Bean.** He formerly was commander of the Fort Huachuca Army Hospital, Fort Huachuca, Ariz.

David G. Williamson Jr. has been appointed administrator of Lewis-Gale Hospital, Roanoke, Va. He previously was administrator of Bedford County Memorial Hospital, Bedford, Va. **Alfred L. Burkholder** succeeds Mr. Williamson in the Bedford post.

Ralph M. Davidson is the new head of Madison Sanitarium and Hospital, Madison, Tenn.

Harold Rolph has been chosen to succeed **Richard Webb** as administrator of Lawrence County General Hospital, Ironton, Ohio. Mr. Rolph joined the hospital's staff in 1952 as business manager and has been assistant administrator since 1956.

Elbert E. Gilbertson has been named administrator of St. Luke's Hospital, Boise, Idaho. He has been assistant administrator and personnel director of the hospital for the last two years and previously served as a staff consultant with James A. Hamilton Associates, Minneapolis. He is a graduate of the course in hospital administration at the University of Minnesota and is a nominee of the American College of Hospital Administrators. Mr. Gilbertson succeeds **Helen B. Ross,** who resigned after 16 years as administrator of the hospital.

Mrs. Chester Smith has been appointed superintendent of Lehi Municipal Hospital, Lehi, Utah, succeeding **Mrs. Leo Ball.**

(Continued on Page 176)

Lehn & Fink
PROFESSIONAL DIVISION

staph newsletter

TWELFTH OF A SERIES WITH SIGNIFICANT SUGGESTIONS FOR CONTROLLING CROSS INFECTIONS

EVER since the first Staph Newsletter, the "significant suggestions" we have been privileged to offer you on staph control have seldom emphasized the phage types and strains of staph or their varying antibiotic susceptibility. Just as you probably do, we consider any strain of staph potentially dangerous and the judicious use of antibiotics the province of the physicians and the Infection Control Committee. In the March 11th issue of The Journal of the American Medical Association (page 886), Doctors Wallmark and Finland reveal the interesting results of comparing strains of the previous ten years with 1959-1960 at Boston City Hospital. 1550 strains were isolated. Among their significant conclusions are:

The proportion of strains of staphylococci resistant to the widely used antibiotics has continued to increase.

The lowest proportion of resistant strains was obtained from outpatients, the proportion increased with length of hospitalization and was highest in the strains obtained at autopsy.

As sensitive staph strains are eliminated by antibiotics, resistant staph persist, multiply and spread.

Fortunately, there is published evidence that staph organisms which have become resistant to antibiotics do not *ipso facto* become resistant to any one of the L&F phenolic disinfectants—Amphyl®, O-syl®, Lysol®, or Tergisyl® detergent-disinfectant. All are broad spectrum microbicides which are not only staphylocidal but also pseudomonacidal, tuberculocidal and fungicidal. And we do have this suggestion—

Write today for your copy of our new infection control kit titled, "Contamination Control That Works...in your Hospital". In a conveniently index-tabbed jacket we've collected a variety of pertinent materials. Whether you're interested in general housekeeping, isolation units, O.R. and recovery, O.B. and maternity, nursery and pediatrics, emergency and outpatients, laundry, or the whole hospital —you'll find in this kit specific "how, where, and when" information on dependable contamination control. Reprints report successful control of infection in well-known hospitals, and how it is being done. Brochures give specific procedures easy to follow in any hospital. The kit is suitable for use by the Infection Control Committee in re-evaluating environmental control throughout the hospital. We'll be glad to send each member an individual copy if you ask us. Please do.

When you're talking to some of the doctors in your hospital, you may want to tell them about a special clinical symposium, "The Hazards of Infection", scheduled for Sunday, June 25, at the Savoy Hilton Hotel in New York City. This is the final session of the annual meeting of the American College of Angiology and the International College of Angiology which precedes the annual AMA meeting. The complete two-hour program with names and professional affiliations of the participants is too long for mentioning here, but if you would like these details please let us know. Perhaps you, too, will want to be there.

From the time our new spray-on form of Amphyl was first discussed in the L&F research lab, I agreed with many of our hospital friends who felt that Amphyl Spray would take care of a lot of difficult disinfection problems. Particularly—odd-shaped surfaces, hard-to-reach areas, also for immobilizing organisms immediately after accidental spills of infectious material, and prior to disinfection, e.g., by flooding. The versatility of Amphyl Spray as a deodorant is also "inspiring" many hospitals. For instance, on the orthopedic service it is being sprayed directly onto the patient's cast to offset malodors. Amphyl Spray lends itself well to this use since it leaves no sticky or greasy residue and no evidence of its having been used except the reduction in odor. As a disinfectant, Amphyl Spray is handy for frequent drenching of the base and understructure of the operating table. Be sure to send for our new bulletin on specific Amphyl Spray procedures.

In a study of one thousand consecutively operated cases from the General Surgical Wards of the University Hospital in Oklahoma City, the infection rate in 537 clean wounds ranged from 3.1% without preoperative antibiotics to 4.0% with preoperative antibiotics. In the 463 contaminated wounds, infections complicated the surgical wound in 11.9% when antibiotics were used postoperatively and in 5.0% when not used. In the clean wounds, infection was nine times greater among patients who received antibiotics postoperatively. In discussing this study, the authors say that it is becoming obvious that their use (prophylactic antibiotics) offers no real protection against the appearance of a wound infection. (American Surgeon 12:781, December, 1960)

Routine de-contamination of floors, objects, surfaces, blankets, and linens can be one of the most economic, effective, and simple control measures against infection and superinfection. Here's why—it reduces the number of organisms available for spread by any route—contact, nasal, or airborne—thus reducing both the excess hospital days and the risk of debilitating infection in both the patient and the hospital personnel.

Please write us for any of the information offered in this letter. If you want copies for teaching purposes or group discussion, please let us know how many you will need. When you have additional questions, our research laboratories and technical advisors are ready to help. I, personally, would like to hear from you at any time.

Robert E. Dickens

Robert E. Dickens
General Sales Manager
Professional Division

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Conducted by Grover C. Bowles Jr.

Gas Sterilization Adds to Life of Surgical Gloves, Tests Show

Leo Cravitz, Dr. P.H.
and Virginia Tyler, R.N.

AMONG the most important factors contributing to glove replacement is the rapid deterioration of gloves that takes place when they are autoclaved at temperatures of 250 F. and higher. A single autoclaving produces a marked decrease in both the elasticity and tensile strength of latex and brown milled gloves. The loss of elasticity results in damage caused by cuts and punctures during surgery and the reduced tensile strength contributes to tearing of the cuff and fingers when the gloves are put on or removed. As a consequence of physical damage, the life of autoclaved gloves rarely exceeds three uses.

A survey* of glove consumption in general hospitals indicated that as many as 42 pairs per bed per year are purchased. A typical example is that of a 416 bed hospital having approximately 170 surgical and 39 obstetrical beds. Annual purchase is approximately 17,000 pairs, or about 40 pairs per bed per year; at this rate, annual glove cost has been approximately $7000.

Since the development of gas sterilization a testing program has been undertaken in laboratories and in the field to determine the effect of the gas process on various commonly used heat-sensitive hospital items. The work was performed with the cooperation of the personnel of several prominent hospitals over the last three years. It was found that many items could be sterilized without fear of damage from high temperatures; but perhaps the most striking discovery was the economies possible with gas sterilization of surgical gloves.

The pertinent data obtained from these studies are summarized here:

1. **Sterilizing gas at a temperature of 130 F. has no deleterious effect on surgical gloves.** There is no appreciable loss in either elasticity or tensile strength of the rubber.

2. **A temperature of 130 F. for four hours will uniformly sterilize gloves that are properly wrapped and packed.** During the testing program hundreds of cycles were bacteriologically controlled, and in no instance was there recorded a failure in sterilization.

3. **The quantity of residual ethylene oxide in the gloves is negligible.** Virtually all of the gas is dissipated within one hour after removal of the glove pack from the sterilizer.

4. **The average life of a glove is extended to approximately 10 uses and glove replacements can thus be reduced by at least 60 per cent.** In terms of dollar savings, an annual glove bill that was formerly $7000 can be reduced to approximately $2800.

Following is the recommended procedure for processing gloves.

1. **Gloves used in clean surgical cases should be deposited in buckets situated in the scrubroom.** Gloves from septic cases should be placed in polyethylene bags and be decontaminated in the sterilizer prior to normal washing procedures.

2. **After the used gloves have been collected, they should be thoroughly washed and rinsed in an automatic washing machine.** The cycle of operation normally includes a cold water prerinse, a warm water rinse,

(*Continued on Page* 110)

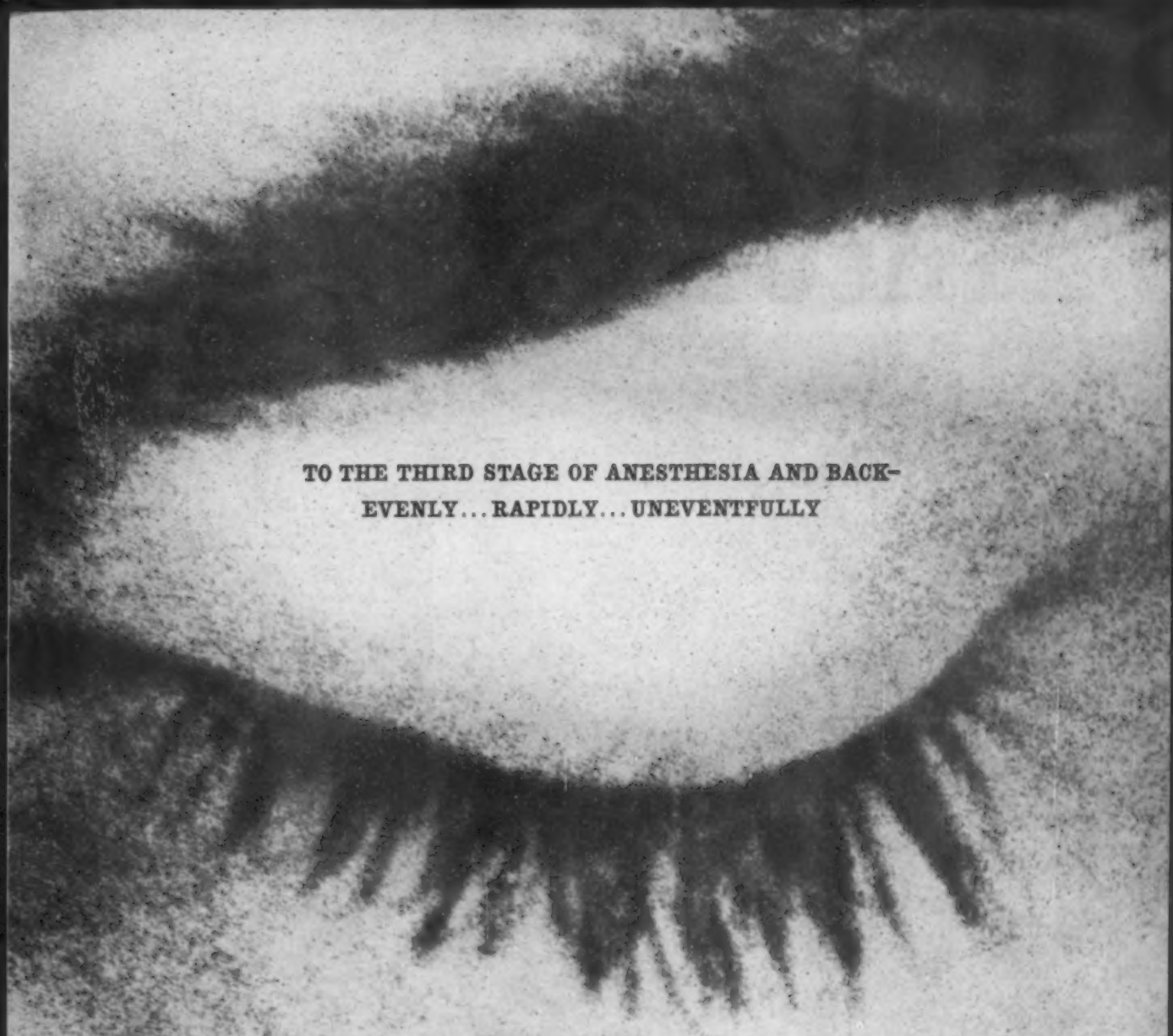
Table 1—Two Plans for Gas Sterilization of Surgeons' Gloves

PLAN	NO. 1	NO. 2
Gas used	Steroxcide "12"	Steroxcide "10"
Sterilizer size	1630 & 2020	2436 & 3660
Initial evacuation	25 inches	25 inches
Humidity level	40%	40%
Gas pressure	8 p.s.i.	25 p.s.i.
Concentration of ethylene oxide	720 mg. per L.	460 mg. per L.
Exposure time	4 hours	4 hours
Final evacuation	25 inches	25 inches
Cost of gas per cycle*	Size / Cost	Size / Cost
	1630 $0.84	2436 $0.84
	2020 $1.68	3636 1.26
		3648 1.67
		3660 2.10

* Above costs are based on use of bulk supply of 270 lb. cylinders of Steroxcide "12." Steroxcide "12" is available also in 100 lb. cylinders at slightly higher cost per pound. Steroxcide "10" is supplied in 60 lb. cylinders.

Dr. Cravitz is microbiologist at Rochester General Hospital, Rochester, N.Y., and Miss Tyler is the former operating room supervisor at that hospital.

*Surgeons Rubber Gloves. A report on the comparative quality of seven brands. New York. Research Department, Hospital Bureau of Standards and Supplies. November 1954.



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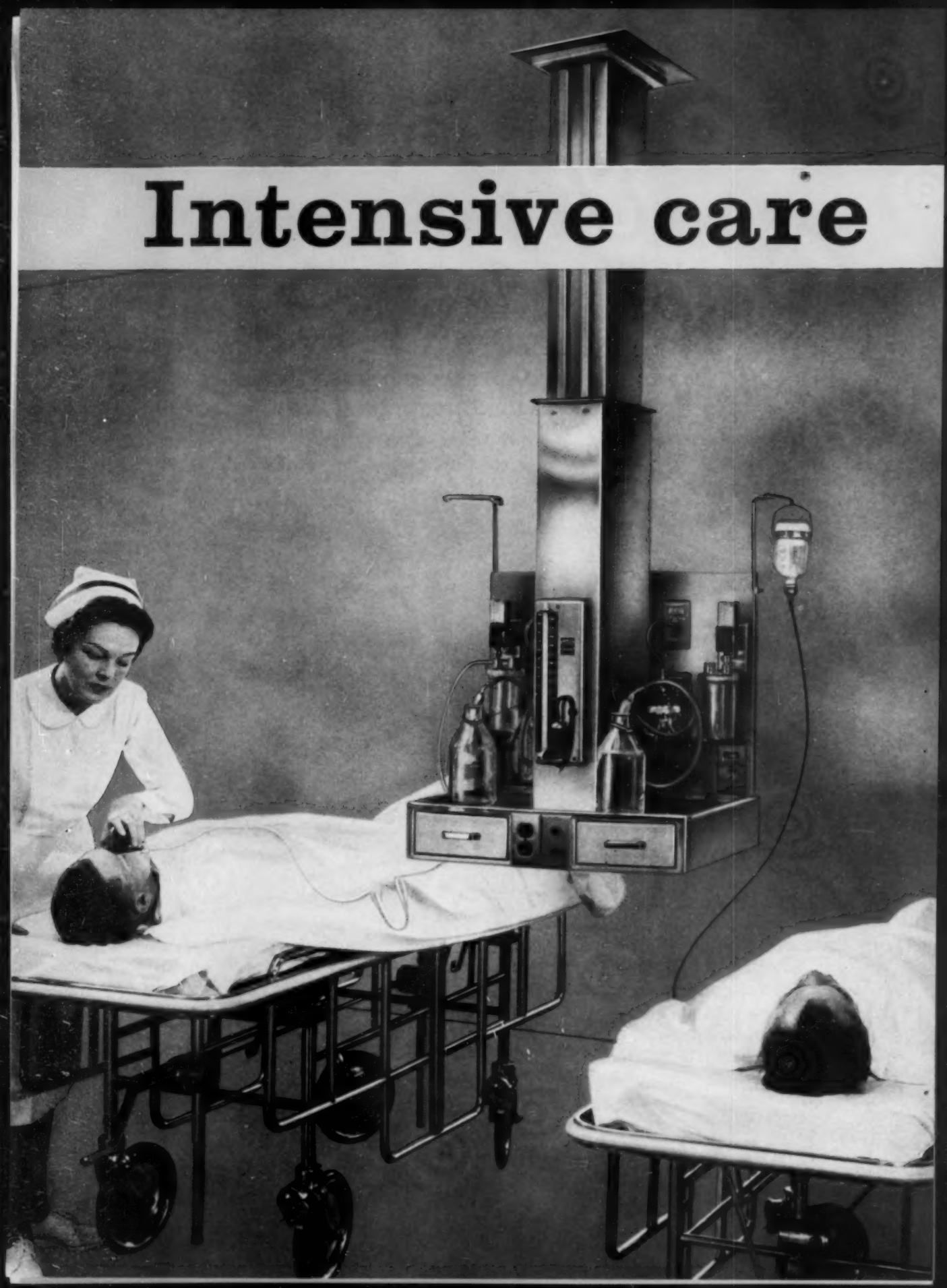

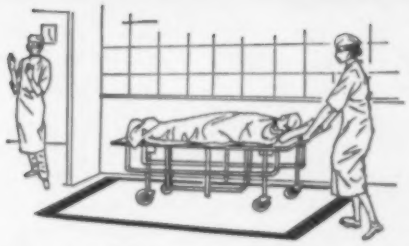

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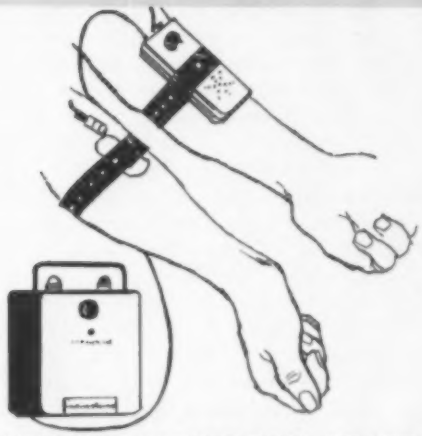

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(*Continued From Page* 106)

a hot water-detergent wash, a hot rinse, and a final warm water rinse.

3. After gloves have been removed from the washing machine, they should be placed in position on a tilted board to allow excess water to drain from the fingers. It is necessary to remove as much excess water as possible before placing the gloves in a glove conditioner for tumble drying. Approximately 100 pairs of gloves can be dried in the "drying compartment" of the glove conditioner during a 30-45 minute cycle.

4. The dry gloves should be checked for leaks either over air testing equipment, or by trapping air in the hand of the glove and rolling the cuff forward to squeeze air into the individual fingers. Holes should be circled and the damaged gloves set aside for patching.

5. Dry, tested gloves should be powdered in the appropriate compartment of the glove conditioner. Approximately 100 gloves can be powdered in less than 10 minutes.

6. The powdered gloves should be placed in a paper or muslin double envelope which will accept a single right or left hand glove in each of its two pockets. Gloves should be folded back so that the cuff just covers the thumb. Paper inserts are not required in the palm of the gloves. If desired, a paper wrapped sachet of powder may be included in this inner wrap.

7. The folded glove envelope with its contents should then be placed diagonally in an outer wrap—a paper sheet 20 inches square. The outer wrap should be of crepe or paper toweling consistency; waxed papers or hard finish water repellent paper should be avoided. The outer wrap should be folded over the inner wrap, one corner at a time. The last corner is the closure fold and it should be fastened with an indicator tape, color-sensitive to ethylene oxide. This tape is extremely valuable since it is almost impossible to differentiate between processed and unprocessed gloves when sterilizing with ethylene oxide.

8. When a gas sterilizer is loaded, individual packs should be placed on edge to avoid excessive stack compression. The packs may be placed on edge either sideways or upright to best suit the shape of available trays. Production capacities for various sterilizer sizes are:

Sterilizer Size	Capacities, Pairs	
16 x 16 x 30"	(1630)	112
20 x 20 x 36"	(2020)	200
24 x 24 x 36"	(2436)	400
24 x 36 x 36"	(3636)	600
24 x 36 x 48"	(3648)	800
24 x 36 x 60"	(3660)	1000

9. Exposure time of four hours at temperature of 130 F. is the recommended sterilizing time for each of the two plans listed in the table on page 106.

Sterility controls adaptable to the ethylene oxide process are:

1. A chart record of each cycle of operation. This record shows the temperature of the chamber as well as the degree of the evacuation and pressure attained during the process.

2. An ethylene oxide sensitive tape which changes color when subjected to the gas. Although this color change follows quite closely the actual exposure times required for sterility, it is to be remembered that this is a chemical indication only and sterility should not be inferred solely from this evidence.

3. Bacteriologic indicator-spore strips which can be inserted in the inner wrap of the glove and can be removed by the bacteriology department for checking sterility of a specific load. The spore which has been found to be most resistant is *Cl. sporogenes.* The contamination level on this strip should not exceed 250,000 per sq.cm. At this level there is inherent a large safety factor, and larger concentrations will not give a realistic evaluation of the cycle time needed. Another resistant spore, *B. globigii,* is available in populations of approximately 500,000 per sq.cm. It is to be noted that the *B. stearothermophilus* used as a heat resistant steam sterilization control should not be used in checking ethylene oxide sterilization since it is not as resistant as the two organisms mentioned. ■

Photographs, courtesy Wilmot Castle Company, Rochester, N.Y.

Powdered gloves should be placed in a double envelope, as shown, with the cuff folded back just over the thumb.

The folded glove envelope should then be wrapped in an outer covering, fastened with pressure-sensitive tape.

How Disposable and Reusable Gloves Compare

On the basis of costs, durability and acceptability to the wearer, disposable surgical gloves compare favorably with reusable ones, this hospital study indicated

Mildred Struve and Eugene Levine, Ph.D.

DISPOSABLE surgical gloves seemed to offer an efficient answer to many problems of processing at the Public Health Service Hospital, Boston, but they also raised questions of cost, durability and acceptability as compared with reusable gloves. Not finding the answers we needed in current hospital literature, we decided to study both types to obtain data on which to base a decision.

The operating room was selected for the initial study because it offered a more controlled setting with fewer variables in use and personnel. Furthermore, it was reasoned, if disposable gloves met the strict requirements for use in surgical operations it could be assumed that they would be satisfactory for less exacting procedures in other areas.

Some of the questions raised in the study were:

COSTS – How do the gloves compare in purchase price? Are there hidden costs in determining the real cost to the hospital? What does it cost to process reusable gloves? What is the discard rate in reprocessing? How much nursing time can be saved if glove processing is eliminated?

DURABILITY – How do gloves compare as to detectable wear during the operation, such as needle pricks, cuts, tears? Undetected wear?

ACCEPTABILITY – What are the criteria for acceptability of surgeons' gloves? How do the gloves compare when the criteria for acceptability are applied?

Studied Processing Costs

The first phase of the study was to determine the cost of processing gloves.

Five lots of gloves were processed in the established manner by regular personnel. The procedure was divided into eight steps which were separately timed. All steps except powdering were done by hand. Labor costs included salaries as well as employer contribution to retirement and group insurance. Supplies included soap, powder and paper wraps. Sterilization costs were omitted as these were the same for both types of gloves. Table 1 shows the breakdown of the various steps and indicates the total cost of processing gloves as 14½ cents per pair.

To know which glove was more economical to use we had to determine how many times the reusable glove is used. The discard rate during the testing process was 30 per cent, which indicated that the average use was three times. Probably few hospitals get as many uses from gloves as they think they do. It is wishful thinking to believe that gloves are used more than three or four times or, as some manufacturers of glove processing equipment have stated, eight to 10 times. Average cost per use was the total of the purchase price and first packaging plus two reprocessing costs divided by three, which equals 23.7 cents per pair. This is a little lower than the 28 cent cost per pair of disposable gloves. However, if the money value of overhead such as space, equipment and maintenance could be estimated, the cost of the reusable glove would be increased above the 28 cent cost of the disposable type. The intangible benefits derived from the use of disposables should not be ignored. Elimination of nonnursing functions from nursing personnel, freeing of valuable space, reducing equipment maintenance, simplifying administrative procedure, and – perhaps the most important of all – elimination of a potential source of infection are all factors that warrant consideration.

The time study showed that an average of 3.2 minutes of personnel time was required to process one pair of gloves. One thousand pairs require 53.5 hours. To process 30,000 pairs

Miss Struve is assistant director of nursing, in-service education, at U.S. Public Health Service Hospital, Boston. Dr. Levine is chief of the statistical analysis branch, Division of Nursing, U.S. Public Health Service.

Adapted from a paper presented to the American Academy for the Advancement of Science, hospital pharmacy section, Dec. 27, 1960, New York.

This report does not necessarily reflect the views of the United States Public Health Service.

of gloves annually requires the entire services of one full-time employe.

To determine the acceptability of gloves to the wearer, criteria were developed with the assistance of the chief surgeon and the operating room supervisor. A questionnaire based on these criteria was checked by each member of the surgical team after each operation. These four groups of gloves were tested:

Group 1 — Reusable gloves, all new.

Group 2 — "Run-of-the-mill" reusables. This group had the average mixture of new and used gloves in general use.

Group 3 — Brand 1 disposables.

Group 4 — Brand 2 disposables.

A total of 1950 individual gloves were tested in 240 major operations. The gloves were randomly assigned to all types of operations of more than 30 minutes duration. All members of the team wore the same type of glove for any given operation.

Findings concerning the acceptability to the wearer are shown in Table 2. There is no significant difference in the unfavorable responses for the new and used gloves. Brand 1 of the disposable gloves received a higher percentage of unfavorable responses to all questions than either group of reusable gloves. Brand 2 of disposables received the fewest unfavorable responses of any of the groups. The question on stretchiness or stickiness from working in fatty tissue was added after the data had been completed on two groups. Brand 2 disposables had the fewest unfavorable responses on this factor. These data indicate that Brand 2 of disposable gloves rated the highest in acceptability on all items and exceeded even the new reusables. In fact, the doctors said they were the best gloves they had ever worn, although in the beginning they had been rather skeptical of any disposable gloves.

Durability was measured by recording the wear that was recognized by the wearer during the operation and that necessitated a change of gloves. The unrecognized wear was determined at the end of the operation by testing all gloves (except those which had been discarded during the operation) for undetected pricks, cuts and so forth. The results are shown in Table 3.

These tests showed no really significant differences in any of the groups when total defects or wear factors were considered. The used reusables scored the highest in undetected defects at 10.1 per cent. Brand 1 scored 8.5 per cent undetected defects. Brand 2 disposables scored the lowest of all in total defects and would seem to be the most durable in use and from these results would be the safest of the brands tested.

Each hospital will have to make its own decisions as to how it spends its money and utilizes personnel time most effectively. Based on the findings of this study, however, it is recommended that serious consideration be given to abolishing all glove processing and adopting disposable gloves in all areas. Whether or not the individual hospital decided to use a prepackaged disposable type of glove or the present reusable type as a disposable glove will depend on the available discounts for quantity buying. What this study shows is the economy and safety achieved by the elimination of all glove processing. ■

TABLE 1 — COST OF PROCESSING REUSABLE GLOVES

Direct labor			**$0.088**
	Washing	**$0.029**	
	Drying	**0.026**	
	Testing	**0.014**	
	Wrapping	**0.019**	
Indirect labor (employer contribution to retirement, etc.)			**0.006**
Materials (powder, wraps etc.)			**0.021**
Cost of processing rejects			**0.030**
Overhead (building space, heat, light etc.)			**unknown**
Total cost per pair — exclusive of overhead			**$0.145**

Breakdown for processing reusable gloves shows total cost per pair to be 14½ cents, exclusive of overhead costs, which were not known.

TABLE 2 — ACCEPTABILITY, PERCENTAGE OF UNFAVORABLE RESPONSES

	Reusable		**Disposable**	
	New	**Used**	**Brand 1**	**Brand 2**
Were the gloves comfortable?	**3.5**	**7.5**	**18.8**	**0.0**
Did the fingers fit well?	**11.5**	**10.5**	**19.5**	**2.9**
Did the wrists fit well?	**8.6**	**6.6**	**17.0**	**1.0**
Was the tactile sensitivity satisfactory?	**1.3**	**3.8**	**40.2**	**1.9**
Was the feel of the gloves satisfactory?	**3.2**	**1.9**	**37.5**	**1.0**
Did the gloves slip on easily?	**2.7**	**2.9**	**14.1**	**2.9**
Were the gloves removed easily?	**0.6**	**4.8**	**12.2**	**1.0**
Were you working in fatty tissue?				
Did the fingers become stretchy or sticky from the fat?		**56.7**		**14.0**

On questions of acceptability to the wearer, Brand 2 disposable gloves received fewest unfavorable responses; Brand 1 disposables received the most.

TABLE 3 — DURABILITY, PERCENTAGE OF DEFECTS

	Reusable		**Disposable**	
	New	**Used**	**Brand 1**	**Brand 2**
Detected wear	**6.9**	**4.6**	**6.7**	**3.8**
Undetected wear	**5.3**	**10.1**	**8.5**	**6.7**
Totals	**12.2**	**14.7**	**15.2**	**10.5**

Tests showed no signficant difference in wear for the four groups, although Brand 2 had fewest detected defects and smallest total.

arresting measure for surgical bleeding

When the customary surgical techniques for capillary hemostasis fail, prompt cessation of oozing may usually be obtained with OXYCEL (oxidized cellulose, Parke-Davis). This absorbable hemostatic conforms readily to all wound areas...assures a clear operating field...helps to shorten operative procedures.

Available in forms for every need: OXYCEL (oxidized cellulose, Parke-Davis). Pledgets (Cotton-type), 2¼ in. x 1 in. x 1 in.; Pads (Gauze-type) (8-ply), 3 in. x 3 in. and 4 in. x 12 in.; Strips (Gauze-type) (4-ply), 5 in. x ½ in., 18 in. x 2 in., 36 in. x ½ in., and 3 yd. x 2 in.; Foley cones (Gauze-type) (4-ply), 5 in. and 7 in. diameters. Sterile as supplied.

Indications: As an adjunct to effect hemostasis in bleeding associated with capillary oozing. ***Use:*** Strips—temporary packing of bleeding cavities, nasal passages, and tooth sockets; pads—temporary packing of surgical beds as after biopsies and to cover more or less extensive areas as in laparotomies; pledgets—in neurosurgery and in dental work for small localized bleeding areas; Foley cones—in prostatectomy.

Precaution: ***Excess amounts should be removed prior to surgical closure to avoid foreign-body reaction.*** Not to be used in sites of infection or following silver nitrate or other escharotic chemical agents. Contraindicated in clean bone surgery when poor vascularization is present and in instances where rapid callus formation is desired. Should be used sparingly in open reduction of fractures and in cancellous bone. Will not withstand heat sterilization. Remove from container aseptically.

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit 32, Michigan

absorbable hemostatic

OXYCEL

Nurses' Responsibility for Use of Intravenous Fluids Is Limited

By Frances Ginsberg, R.N.

SINCE nurses are not trained as either pharmacists or physicians, intravenous therapy is often beyond their legal responsibility.


Frances Ginsberg

By injecting medications into intravenous fluids, the nurse is doing what should be the responsibility of either the pharmacist or the physician. This depends on whether the medication is injected before therapy begins or while it is being administered. With an increasing number of drugs being administered intravenously, it has become important that pharmacists and physicians take a more responsible role, and that the nurse avoid exposing herself to the possible consequences of administering medications of which she has little knowledge, for which she has not been trained, and in a way that permits a large margin for error.

The increasing use of such commercially prepared fluids as colloids and electrolytes for intravenous therapy should place greater demands upon the pharmacist and his staff.

Since, as with any other medication, they are primarily responsible for knowing both the content and usage as prescribed by the physician, they should not delegate or force the personnel in central service or in the operating room to accept the responsibility of dispensing these fluids to the patient.

In the labor room there is another cause for alarm to the nurse who is conscious of her legal and moral limitations and responsibilities.

This has to do with the use of drugs designed to be administered intravenously to induce labor. The intravenous injection should, in my opinion, be started by the physician, who should then remain in the suite throughout its course. He should not delegate to the nurse the responsibility of watching the patient and notifying him either when the drug has taken full effect or when something untoward is happening. It has been shown that many of the drugs cause severe reactions that require immediate attention by a physician. Nurses are neither trained nor can they be held responsible for ministering to such reactions.

"How can a nurse refuse to accept certain orders for administering a drug or watching a patient?"

This is a question I am often confronted with when I broach this touchy subject. My answer is simple.

A nurse is a professionally trained, skilled and responsible person. She is a colleague of the physician and the pharmacist. As such, she is an important member of the hospital team.

However, the nurse is neither the whole team nor should she exceed her professional training or the limits of her legal and moral responsibility by substituting for the physician or the pharmacist. ■

Miss Ginsberg is a consultant on operating room nursing and hospital aseptic technics and a member of the Bingham Associates Program at Boston's New England Center Hospital.

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Written Policies and Procedures Improve Pharmacy Management

By Grover Bowles Jr.

WRITTEN policies and procedures promote understanding, consistency and continuity, which are necessary for efficient pharmacy service. More important, they promote planning which would not otherwise be done.

Grover Bowles Jr.

For most of us, the mental gymnastics required to commit even routine procedures to writing has a detergent effect that is beneficial in verifying our thinking. Gaps, contradictions and inconsistencies that dull pharmacy efficiency come into focus more clearly when we put them on paper.

Policies and procedures should be spelled out in clear, precise language and, where possible, the rationale or the "why" of the policy or procedure should be given. Of course, departmental policies and procedures must not conflict with over-all hospital policies.

Here is a check list of some policies and procedures that are needed in the daily operation of most hospital pharmacies and should be spelled out in writing.

1. Purchase of pharmaceuticals.
2. Filling prescriptions for hospital employes.
3. Filling prescriptions for outpatients.
4. Filling prescriptions for take-home medication.
5. Accepting prescriptions by telephone.
6. After-hours pharmacy service.
7. Obtaining drugs not listed in the formulary.
8. Dispensing investigational drugs.
9. Reporting errors occurring in pharmacy.
10. Pricing.
11. Narcotic and barbiturate control.
12. Inventory control.
13. Repackaging controls.
14. Bulk compounding controls.
15. Filing pharmaceutical information. ■

Pharmacy Facing Its 'Gravest Hour,' Grover Bowles Warns Association

CHICAGO. — The pharmacist is facing his gravest hour, Grover Bowles Jr., chairman of the American Pharmaceutical Association's House of Delegates, warned his colleagues at the 108th annual meeting of the association here last month.

"At no time since William Davis opened his apothecary shop in Boston in 1646 have the affairs of our profession been in a more crucial state," Mr. Bowles said.

"Already we have undergone a thorough physical examination by Dr. Kefauver and have been referred to the federal courts for additional diagnosis and treatment," he explained. "This is pharmacy's gravest hour."

The time has come, he said, for pharmacists to "stand up and defend the cost of providing good pharmacy service." ■

Hospital-Specialist Conflict Is Primarily a Matter of Economics

By Robert S. Myers, M.D.

ONE of the recurring conflicts on the hospital scene is the conflict between administration and certain medical specialty groups, such as the pathologists and the radiologists, over who is going to get how much of the patient's medical care dollar.

Essentially, the facts are these: Hospitals are having a hard time making ends meet; costs are skyrocketing, and the public is complaining about the high cost of hospital care.

The hospitals feel that one way to help balance the budget, to keep the charges down, and to satisfy the patient is for the hospital to share in the income of those medical services that are housed within the hospital, and that make a considerable amount of money. These are the pathologists' and the radiologists' services.

Moreover, the hospitals contend that they have granted these groups an actual monopoly in the practices of their specialties, in that no competitors, regardless of qualifications, can establish their practices in the hospitals. Administration feels that the pathologists and the radiologists should pay for this privilege.

On the other hand, the specialist groups contend that any sharing of the income from their practices by the hospital puts the latter in the practice of medicine, that this is unethical, and, of even greater importance, that this causes deterioration of the quality of patient care.

They maintain that they are practitioners of medicine and, as such, should not be hired by the hospital, nor should the hospital be paid more than a just rent for the use of its facilities.

The specialists are on firm ground in their belief that every man is worthy of his hire and that no one should profit excessively from the labors of another. On the other hand, hospitals show a laudable concern in their desire to safeguard the patient's pocketbook.

But there are two things that are beyond our comprehension. First, it is unreasonable that the manner of payment of specialists has anything whatsoever to do with the quality of patient care.

Common sense denies this, for the splendid care given throughout the years by professors who have been paid by medical schools, by salaried staff members of distinguished clinics, and by physician employes of Veterans Administration hospitals is proof that employment on a salary does not affect adversely the quality of care.

In the second place, we fail to understand why hospitals are so chary about putting their charges where they logically should be.

A hospital differs from a hotel in that many vital and expensive services that are not apparent to the patient must be maintained in order to render adequate service. Any other successful business enterprise would adjust the charges to reflect the actual cost plus a little profit, and it would educate the public to accept this need.

Since this conflict between specialists and hospitals is concerned primarily with economics, rather than ethics, and since the economics of medical practice varies greatly between communities, the solution should be left to each hospital and its specialists to work out at the local level according to the patients' interests and the community's needs. ■

Conducted by Jane Hartman

Dietary Policies Help Workers Start and Stay

With workers, as with foods, much depends on how they are prepared. The induction and orientation programs used in this food service department help workers perform satisfactorily and the written work policies help keep them satisfied

Steve J. Soltis and Katherine D. Spencer

HIT-AND-MISS personnel policies, careless selection and induction of employes, favoritism in handling promotions or grievances, and substandard wages create chaos in the kitchen and produce effects that reach all the way to the patient's bedside.

Mr. Soltis is administrator, and Mrs. Spencer is director of the nutrition and dietary service, Beckley Memorial Hospital, Beckley, W. Va., Miners Memorial Hospital Association.

This is the second part of an article describing the facilities and operation of the food service department at Beckley Memorial Hospital. The first part appeared in the April issue. The hospital was designed by Isadore and Zachary Rosenfield, New York.

The equipment and layout for the nutrition and dietary service of Beckley Memorial Hospital, Beckley, W.Va., Miner's Memorial Hospital Association, described last month, provide an orderly work setting. But it is up to the hospital administrator and the director of the department to create a favorable work climate for employes.

Here are some of the personnel policies we have worked out to achieve this aim:

Photos for this two-part article and this month's cover, courtesy Alexandre Georges, New City, N.Y.

On-the-job training program is essential in teaching food service employes such tasks as serving food according to the procedure used at an individual hospital. Employes at Beckley Memorial were taught one step at a time.

Personnel Policies

Beckley Memorial Hospital has written personnel policies which apply to all services, including the nutrition and dietary service. They cover: the eight-hour day, 40 hour week, shift differential payments for evening and early morning shifts, overtime pay in excess of eight hours a day or 40 hours a week or holidays worked, seven paid holidays, vacation and sick leave, maternity leave, promotions, transfers, social security, special retirement benefits, and employe health benefits. These are also the basic personnel policies for all 10 of the Miners Memorial hospitals.

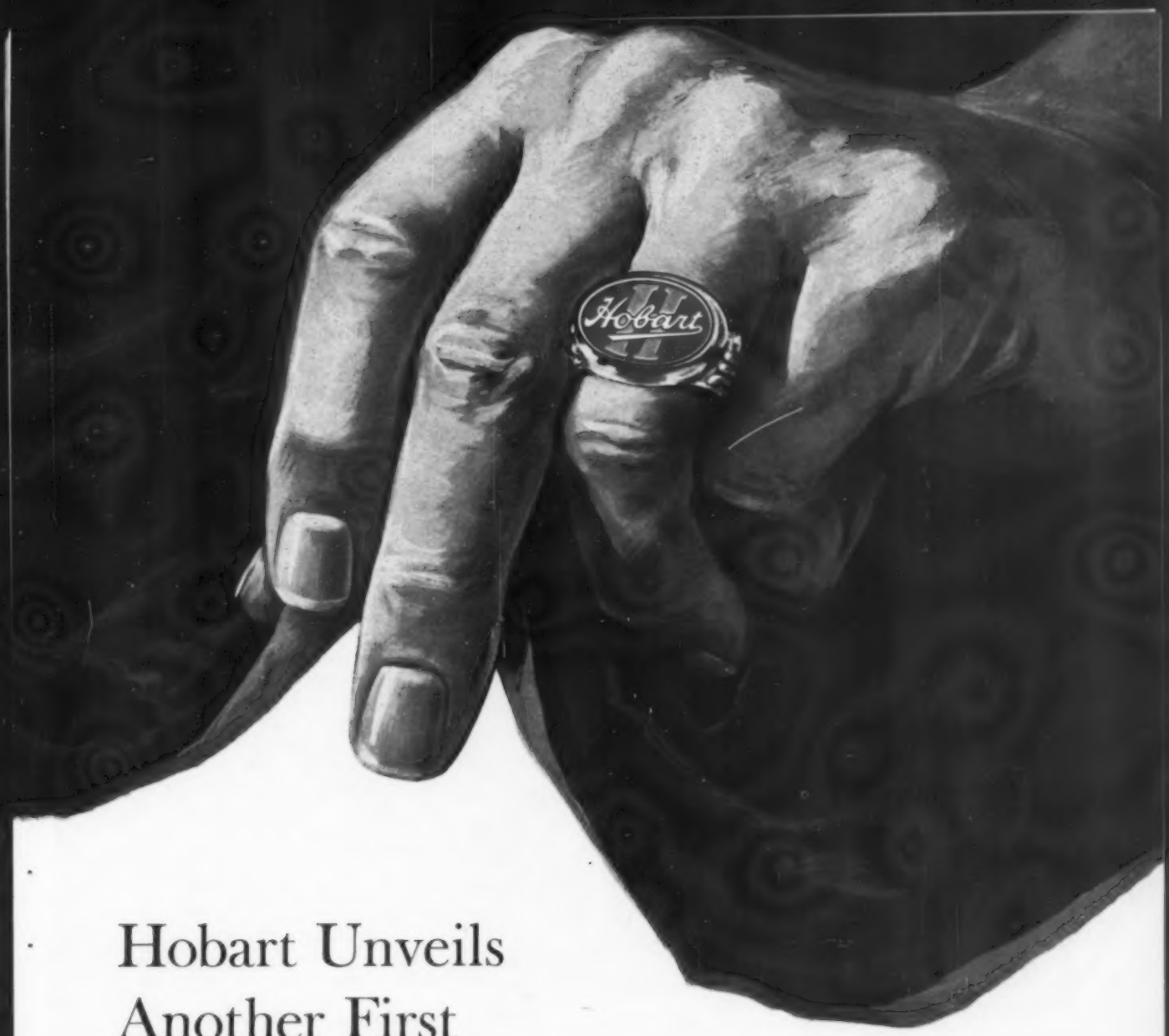
Job Descriptions

The staffing plan calls for 13 different classifications, of which only three are professional positions. The total number of jobs is 54. This includes the director, assistant director, and two staff dietitians who are trained hospital dietitians.

A job description has been prepared for each position covering the following points:

1. Title of position.
2. Location of position.
3. Summary and detailed description of duties and responsibilities.
4. Requirements for education, experience, skills, registration (if applicable).

(*Continued on Page* 122)



Hobart Unveils Another First at the National Restaurant Show

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BECKLEY MEMORIAL HOSPITAL
NUTRITION AND DIETARY SERVICE
CHECK LIST FOR INDUCTING NEW EMPLOYES

Name:	Date	Employe's Initials
I. GENERAL INFORMATION		
1. Best way to get to work		
2. Parking rules and facilities		
3. Entrance to be used		
4. Time of starting and quitting work		
5. Rules on tardiness and absences		
6. Lunch and rest period times		
7. Location of washrooms and lunchrooms		
8. Recreational facilities		
9. Vacations, holidays, health program		
10. Probationary periods		
II. WAGE AND SALARY ADMINISTRATION		
1. Method of calculating pay		
2. Payday		
3. Where he gets paid		
4. Overtime		
5. Shift differential		
6. Annual increment		
7. Payroll deductions		
III. SAFETY INFORMATION		
1. Special hazards and safety regulations		
2. First aid		
3. Reporting accidents		
4. Fire regulations		
5. Fire-fighting equipment		
IV. SECTION AND DEPARTMENT INFORMATION		
1. Organization of department and units		
2. Names of supervisory personnel		
3. Rules and regulations of department		
4. Uniforms or dress required		
5. Whom to notify if unable to work		
6. Names of fellow workers		
7. Meaning of whistles, signals		
8. Smoking regulations		
9. Fan operation		
V. TRAINING INFORMATION		
1. Learning period		
2. What he shall be trained to do		
3. Who will train him		
4. Where to get information and help		
Specified job		
Clean-up methods		
Orientation — tour		
Personal hygiene		
Sanitary food handling		
Sanitary dish handling		
Placement of food and utensils on tray		
Lifting properly		
Leave time		
Food handler's course		
Review of food handler's course		

Check list is used to assure that new employes receive necessary information. Employe initials each item on the list when he is sure that he understands it.

Food Supervisors Give Employes a Good Start

(*Continued From Page* 120)

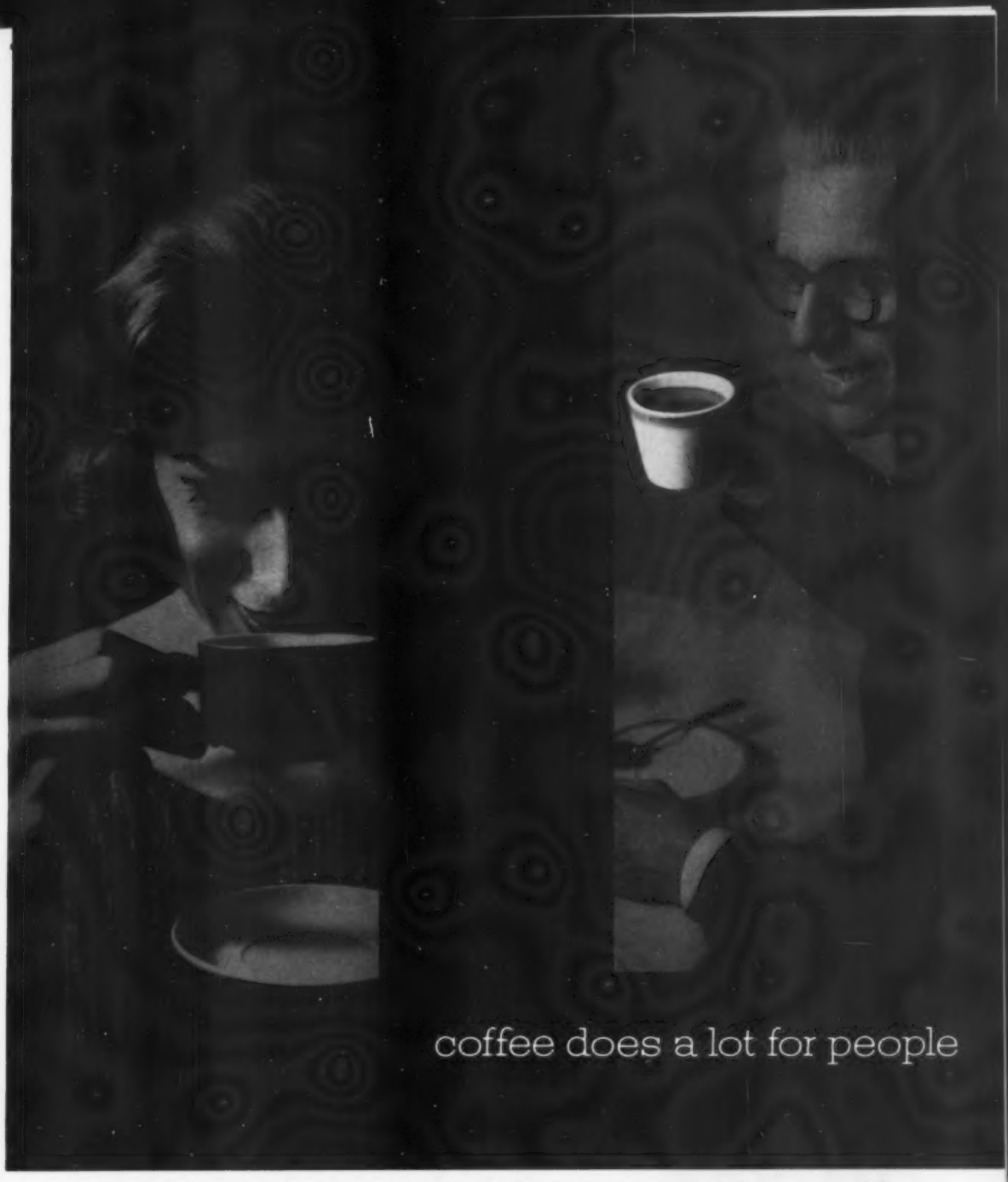
5. Supervision, received from and given to.

Salary Grades

The system of salary grades used throughout the Miners hospital system clearly states the rate of pay from minimum to maximum. Each position is assigned a salary grade. The 13 positions in the dietary service at Beckley are classified in eight different salary grades. There are five steps within each grade. An employe receives an automatic annual increment of a specified amount on the anniversary of his employment through the fifth step in any particular grade. If he is promoted to a position in a higher grade, his increment is larger in the higher grade.

Orientation and Induction

Written personnel policies, job descriptions, established and fair rates of pay help to attract and hold competent, reliable staff — provided each employe knows and understands what these mean for him. After the director has made as careful a selection as possible, the new employe must be introduced to his job in a manner that will help him perform satisfactorily. Since the majority of employes in the nutrition and dietary service are nonprofessional persons, often with limited educational and medical care backgrounds, a major effort must be made to orient them to hospital food service. This can be done successfully when the director sees to it that all supervisors are thoroughly familiar with the hospital's philosophy of patient care, the hos-



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pital policies and procedures, physical facilities, and the relationships of the nutrition and dietary service to other services.

At Beckley Memorial Hospital, most nonprofessional food service employes receive their orientation and continued inservice training from one of the five food supervisors. Our food supervisors are not trained dietitians but must have at least two years of practical experience in quantity food preparation and experience or special training for supervisory duties. They have been trained by the director to conduct an inservice training program which includes, besides orientation and induction of new employes, on-the-job training and continuing development of experienced employes. The food supervisors also teach the food handlers course required by state law for all new employes.

The indoctrination and orientation program for food service workers requires eight hours of intensive training. During this period the new employe receives a copy of the description of his position and a check list (see accompanying sample on page 122) indicating other information he needs. After an item has been explained and both employe and supervisor are satisfied that the employe understands, he initials that item on the check list. He is then held responsible for using that information correctly.

Instruction by demonstration and example is given by the food supervisor until the new employe is able to give a satisfactory demonstration of the required procedures for his job. Then, under the guidance of the food supervisor, he receives actual work assignments with an experienced employe. After one part of the job is learned, he is assigned to another experienced employe to learn another phase of the job until he has had as many as five or six such assignments. With this kind of induction, the new employe learns from the start to perform according to the policies and procedures of the hospital.

Continued Training

A section of the operations manual of the Miners Memorial Hospital Association states: " 'On-the-job' or 'inservice' training will be given each employe where indicated to assist in the development of his ability to perform his work satisfactorily." Every supervisor knows that some employes have more potential than others for assuming responsibility and achieving maximum job efficiency. The food service supervisor is responsible for helping employes to develop whatever potential they have.

Supervisors periodically review the accepted methods of doing a job to determine whether the present procedure is necessarily the best way. If not, new procedures — often suggested by the person on the job — are introduced and tested. Special instruction is given when a new piece of equipment is introduced or when new policies affecting the food service are put into effect. Experienced employes must be secure enough in their grasp of the fundamentals of their jobs to be flexible and to apply their knowledge to changing conditions.

Performance Review

Supervisors prepare performance appraisals at regular intervals, the director preparing those for the dietitians and food supervisors, the food supervisors those for all kitchen and cafeteria employes. The reports are reviewed and discussed with the employe individually to give opportunities for questions.

Small irritations, misunderstandings or personality clashes are inevitable in a busy hospital food service. The method used to resolve such difficulties determine whether or not small troubles become large ones. We have an established grievance procedure with each step described in detail. Complaints and grievances are first taken up with the employe's immediate supervisor. If no agreement is reached, a written grievance is referred to the grievance committee (employe representatives) and to the various levels of supervision and administration as the case warrants.

People Make the Service

A trained and organized staff, working in a physical plant geared to the patients' needs, make the nutrition and dietary service at Beckley Memorial Hospital a key service in total patient care. The well planned physical plant would be worth little without a work climate which encourages employes to work efficiently and coordinate food service with other hospital services, particularly nursing, housekeeping and medical services. ■

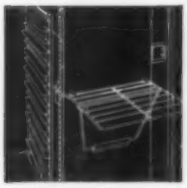
continuous *air recirculation**

holds all compartment temperatures at proper serving level

Two fans gently and constantly ré circulate hot and cold air around filled trays even while the cart is being moved to the patient floor.

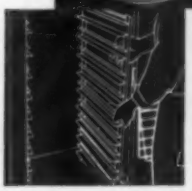
While in transit, special rechargeable batteries operate two fans inside the cart. This continuous air ré circulation prevents the hot and cold air from forming stagnate pockets. Door operated switches automatically shut fans off while trays are being assembled.

Designed to carry 20 hot and 20 cold trays, Southern's new *DIET-TRAY* Cart is preheated and precooled by electricity in the kitchen for approximately 30 minutes before the food is placed in the cart. During this preconditioning period, the special batteries are being recharged.



Plastical coated tray shelves have door-locking feature when in service position.

Floor personnel assemble complete tray at convenient working height.



One-piece tray slides lift out to allow thorough compartment cleaning.

Entire power unit removes for repair or replacement.

Removable panel with special rechargeable batteries and thermostatic controls.

For easier maintenance—compressor compartment housing and coffee shelf lift off as a single unit.

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For additional information, use postcard facing back cover.

U.S.D.A. Unscrambles Egg Buying: Provides a Standardized Grading Service

Elizabeth A. Handy

A GRADING service for poultry and eggs is now available to hospital dietary departments. The service, similar to the U.S. Department of Agriculture's meat grading program,[1] is the U.S.D.A. Acceptance Service for Poultry and Eggs.

Here is how it works:

The grading service is provided on a fee basis.

Food service buyers set up specific requirements for their egg and poultry purchases. Prior to delivery an official U.S.D.A. grader will inspect and grade the eggs or poultry for compliance with the requirements.

Each package is inspected and those that are acceptable will be marked with the U.S.D.A.'s official stamp.

Inspectors Follow Specifications

To use the Acceptance Service,[2] the buyer writes specifications for the items needed, indicating the kind, type, class, size and quality of the eggs or poultry.

If desired, a grader will assist the buyer in preparing specifications. It is important that the buyer specify that all deliveries be examined by a U.S.D.A. grader and officially "accepted" as meeting the specifications. To provide added assurance of quality and condition, it is wise to indicate that the acceptance examination be made as near as practicable to the delivery date.

The buyer should include the following information in writing the specifications for poultry: kind (chickens, turkeys, ducks, geese or guineas); type (fresh, chilled or frozen); class (physical characteristics such as young tom or hen turkey); size (weight of individual bird), and grade (U.S. Grade A is suggested for items which are to be served whole, halved or quartered).

Eggs Checked for Size, Grade

In ordering shell eggs the specifications should include the U.S. grade and weight class desired.

U.S. Grade AA and U.S. Grade A are recommended for poaching, frying and shell cooking. U.S. Grade B or C eggs may be used in other dishes.

Weight classes are based on minimum weight per dozen: jumbo, 30 oz.; extra large, 27 oz.; large, 24 oz.; medium, 21 oz.; small, 18 oz., and peewee, 15 oz.

For frozen and dried egg products the Acceptance Service stamp indicates that these products were prepared from wholesome eggs and under sanitary conditions. ■

Miss Handy is home economist for the standardization and marketing practices branch, poultry division, United States Department of Agriculture, Washington, D.C.

[1]Hartman, Jane: Acceptance Service Inspections Assure Uniform Quality Meats. Mod. Hosp. 95:128 (October) 1960.

[2]Information or requests for service may be obtained from the Poultry Division, A.M.S., U.S.D.A., Washington 25, D.C., or from the supervisor of the following area offices: Customs Building, 2d and Chestnut Streets, Philadelphia 6; U.S. Customs House, 610 S. Canal Street, Chicago 7; Iowa Building, Des Moines 9; 180 New Montgomery Street, San Francisco.

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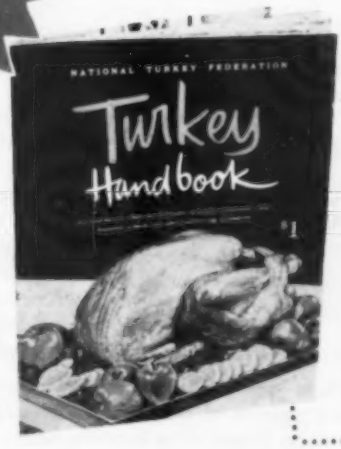

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Dietary Practices Often Differ From Accreditation Standards

By Jane Hartman

IN A recent communication, Dr. Kenneth B. Babcock, director of the Joint Commission on Accreditation of Hospitals, urged all hospitals to accept the J.C.A.H. standards as minimal, and to make every effort to exceed them.

"In every instance specific local laws and ordinances should be obeyed," Dr. Babcock emphasized. This will, of course, refer to local fire and building codes and the regulations of local public health and sanitation departments.

Here are the official "standards" of the commission relating to the dietary department:

1. There shall be an organized department directed by qualified personnel and integrated with other departments in the hospital.
2. Facilities shall be provided which meet the requirements of the local sanitary code for the storage, preparation and distribution of food for the general dietary needs of the hospital. These shall include facilities for the preparation of special diets.
3. There shall be a qualified dietitian on full time, or on a consultative basis and, in addition, administrative and technical personnel competent in their respective duties.
4. There shall be a systematic record of diets correlated with the medical records.
5. Departmental and interdepartmental conferences shall be held periodically.

It is the opinion of the Joint Commission that this department should be under the supervision of a qualified dietitian (preferably A.D.A. registered) on a full-time basis if possible, or on a consultative, part-time basis in smaller hospitals.

In visiting a hospital, the surveyor evaluates this department on the basis of cleanliness, proper and adequate refrigeration, dishwashing and garbage disposal facilities, safe practices in the preparation and transportation of food, and the controls established to ensure proper diet therapy.

The commonest faults reported by surveyors are:

1. Lack of thermometers and temperature controls in large refrigerators.
2. Lack of temperature and thermostatic controls on dishwashing apparatus, and failure to use these controls when they are present. Hand drying of dishes.
3. Poor and unsanitary garbage control and disposal.
4. Storage of uncovered food in the same refrigerator with drugs.
5. Failure to clean ice storage bins. This is quite frequently found.
6. Presence of unimaginative, unpalatable, repetitious, stereotyped special diets.
7. Poor housekeeping and sanitation in the department.
8. Uninstructed personnel for the handling of food.
9. Poor transportation of food, resulting in unpalatable food.

These standards and observations of Dr. Babcock's experience in the inspection of hospitals are general, but fair and reasonable, and will be discussed in future columns. ■

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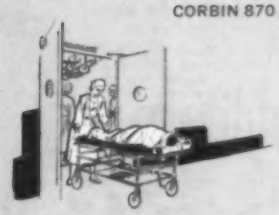

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IT PAYS TO MAKE IT **CORBIN** THROUGHOUT

Menus for June 1961

Clara Wells, R.N.
Dietitian
Frederick Ferris Thompson Hospital
Canandaigua, N. Y.

1

Apricot Nectar
Scrambled Egg, Bacon
•
Vegetable Soup
Roast Veal, Gravy
Mashed Potatoes
Frozen Spinach
Apricot-Fig Salad
White Cake
•
Creamed Chicken Soup
Cold Ham
Creamed Potatoes
Wax Beans
Tossed Salad, Bleu
Cheese Dressing
Applesauce

2

Half Grapefruit
Soft Cooked Egg
•
Clam Chowder
Fried Fish
Mashed Potatoes
Peas
Coleslaw
Apple Pie
•
Creamed Asparagus-
Celery Soup
Macaroni and Cheese
Buttered Beets
Carrot-Raisin Salad
Apricots, Cookies

3

Pineapple Juice
Poached Egg, Bacon
•
Beef Minestrone
Swiss Steak
Mashed Potatoes
Mixed Vegetables
Lettuce Wedge Salad
Apple-Oatmeal Bar
•
Beef Vegetable Soup
Canadian Bacon
Baked Potato
Wax Beans
Lime Perfection Salad
Applesauce

4

Grape Juice
Poached Egg, Bacon
•
Consomme
Roast Turkey, Dressing
Mashed Potatoes, Gravy
Squash
Cranberry-Orange Gelatin
Ice Cream
•
Potato Soup
Fruit Salad Plate With
Cottage Cheese
Celery Hearts, Carrots
Potato Chips
Angel Food Cake

5

Mixed Fruit Juice
Poached Egg, Bacon
•
Turkey Noodle Soup
Baked Ham, Orange Sauce
au Gratin Potatoes
Lima Beans
Waldorf Salad
Gingerbread
•
Tomato Soup
Ground Beef Patty
French Cut Beans
Lime Gelatin With
Cottage Cheese
Pear, Cookie

6

Orange Juice
Poached Egg
•
Cream of Celery Soup
Chicken Fricassee, Rice
Frozen Peas
Tossed Salad
Ranch Pudding
•
Chicken Gumbo Soup
Cube Steak
Baked Potato
Buttered Corn
Carrot-Cabbage Salad
Peaches

7

Apricot Nectar
Soft Cooked Egg
•
Asparagus Soup
Roast Lamb, Mint Jelly
Mashed Potatoes, Gravy
Scalloped Tomatoes
Stuffed Prune Salad
Rice Pudding
•
Bean Soup
Creamed Chipped Beef
Baked Potato
French Cut Beans
Cottage Cheese-Orange
Salad
Cherries

8

Frozen Orange Juice
Poached Egg, Bacon
•
Scotch Broth
Roast Beef, Gravy
Oven Browned Potato
Squash
Tossed Salad
Bread Pudding
•
Chicken Noodle Soup
Canadian Bacon
Creamed Potatoes
Cabbage Salad
Apricots, Sugar Cookie

9

Pineapple Juice
Scrambled Eggs
•
Clam Chowder
Baked Cod With Cheese
Sauce
Frozen Broccoli
Cottage Cheese-Red
Apple Ring Salad
Lemon Pie
•
Mushroom Soup
Salmon Loaf, Creamed
Peas
Baked Potato
Perfection Salad
Applesauce

10

Banana
Poached Egg, Bacon
•
Minestrone
Baked Veal in Tomato
Sauce
Mashed Potatoes
Green Beans
Fruit Salad
Peach Cobbler
•
Beef Vegetable Soup
Broiled Lamb Chop
Creamed Potatoes
Peach-Date Salad
Gelatin, Custard Sauce

11

Applesauce
Hot Cakes, Sausage
•
Beef Noodle Soup
Barbecued Chicken
Mashed Potatoes
Carrots
Lettuce Wedge
Strawberry Sundae
•
Chicken Vegetable Soup
Beef-Noodle Casserole,
Tomato Sauce
Frozen Peas, Carrots
Fruit Salad
Frosted White Cake

12

Blended Juices
Poached Egg, Bacon
•
Split Pea Soup
Ham, Orange Sauce
Candied Yams
Green Beans
Tossed Salad
Butterscotch Pudding
•
Creamed Vegetable
Chowder
Baked Lamb Chops
Creamed Potatoes
Asparagus
Carrot-Cabbage Salad
Pineapple Chunks

13

Orange Juice
Poached Egg, Bacon
•
Chicken Chowder
Liver
Scalloped Potatoes
Kale
Waldorf Salad
Strawberry Shortcake
•
Beef Noodle Soup
Breaded Veal Cutlet
Baked Potato
Wax Beans
Lettuce Wedge
Gelatin, Cookies

14

Pineapple Juice
Scrambled Eggs
•
French Onion Soup
Steak
Mashed Potatoes
Brussels Sprouts
Tossed Salad
Fruit Gelatin
•
Cream of Mushroom
Soup
Cold Ham
au Gratin Potatoes
Asparagus
Perfection Salad
Applesauce

15

Prunes
Hot Cakes, Bacon
•
Barley-Beef Soup
Roast Beef, Gravy
Mashed Potatoes
Mixed Vegetables
Red and Green Cabbage
Salad
Tapioca Pudding
•
Chicken Gumbo Soup
Corned Beef Hash With
Poached Egg
French Spinach
Carrot-Raisin Salad
Cherries

16

Fruit Punch
Scrambled Eggs
•
Tomato Soup
Scallops, Tartare Sauce
Mashed Potatoes
Harvard Beets
Deviled Egg Salad
Cherry Pie
•
Clam Chowder
Macaroni and Cheese
Frozen Peas
Tomato Salad
Peaches, Cookie

17

Grapefruit Sections
Soft Cooked Egg
•
Beef Noodle Soup
Corned Beef
Sauerkraut
Fruit Salad
Rice-Raisin Pudding
•
Split Pea Soup
Ground Beef Patty on
Bun
Frozen Corn
Asparagus Salad
Crushed Pineapple

18

Banana
Poached Egg
•
Chicken Rice Soup
Half Cornish Hen,
Dressing
au Gratin Potatoes
Glazed Carrots
Tossed Salad
Ice Cream
•
Beef Vegetable Soup
Ham and Cheese Sand-
wich, Pickle
Mixed Vegetables
Cottage Cheese Salad
Peaches, Cookie

19

Apricot Nectar
Soft Cooked Egg
•
Potato Soup
Roast Pork, Dressing
Creamed Potatoes
Applesauce
Cranberry-Apple Salad
Blanc Mange, Orange
Sauce
•
Chicken Soup
Hot Beef Sandwich
Asparagus
Tossed Salad
Fruit Cocktail

20

Grapefruit
Fried Egg, Sausage
•
Creamed Corn-Bacon Soup
Chicken Fricassee
Saffron Rice
Frozen Peas
Peach-Plum Salad
Lemon Pudding
•
Bean Soup
Meat Loaf
Baked Potato
Carrots
Tomato Salad
Pears

21

Mixed Juices
Poached Egg, Bacon
•
Consomme With Noodles
Roast Lamb, Mint Jelly
Mashed Potatoes, Gravy
Squash
Minted Pineapple Fruit
Salad
Boston Cream Pie
•
Chicken Chowder
Canadian Bacon
Creamed Potatoes
French Cut Beans
Lettuce, Russian Dressing
Applesauce

22

Grapes
Scrambled Eggs
•
Beef Barley Soup
Fried Chicken, Gravy
Mashed Potatoes
Coleslaw, Celery Seed
Dressing
Cherry Cobbler
•
Split Pea Soup
Hamburger
French Fried Potatoes
Wax Beans
Tomato Aspic Salad
Peaches

23

Tomato Juice
Poached Egg, Muffin
•
Fish Chowder
Broiled Lobster Tail
au Gratin Potatoes
Broccoli
Tossed Salad
Sherbet
•
Tomato Soup
Baked Egg Souffle,
Tomato Sauce
Asparagus
Carrot-Cabbage Salad
Banana Slices in
Orange Juice

24

Orange Juice
Fried Egg, Bacon
•
French Onion Soup
Roast Beef, Gravy
Mashed Potatoes
Scalloped Tomatoes
Celery, Carrot Sticks
Fresh Strawberries
•
Tomato Juice
Creamed Chipped Beef
Baked Potato
Tossed Salad
Baked Custard

25

Pineapple Juice
Hot Cakes, Sirup
•
Minestrone
Roast Turkey, Dressing
Mashed Potatoes, Gravy
Buttered Beets
Molded Orange Salad
Pumpkin Pie
•
Chicken Rice Soup
Lobster Newburg on
Toast Points
Peas and Carrots
Peach and Cottage Cheese
Salad
Brownies

26

Orange Sections
Poached Egg
•
Turkey Noodle Soup
Roast Veal, Gravy
Browned Potatoes
Spinach
Spiced Apple Salad
Ice Cream
•
Bean Soup
French Rolls Stuffed
With Ham Salad
Deviled Egg Salad
Gelatin

27

Grape-Apple Juice
Waffles, Sirup
•
Cream of Tomato Soup
Club Rib Eye Steak
Mashed Potatoes
Boiled Onions
Tossed Salad With
Chinese Noodles
Apple Betty
•
Chicken Chowder
Sliced Ham
Creamed Parslied
Potatoes
Tomato-Cucumber Salad
Pineapple Cubes

28

Apple Juice
Sausage, Muffin
•
Tomato Soup
Liver
Scalloped Potatoes
Dutch Green Beans
Spiced Apple
Fruit Cup, Cookie
•
Vegetable Soup
Creamed Chipped Beef on
Toast
Mixed Vegetables
Waldorf Salad
Cubed Gelatin

29

Grapefruit Sections
Poached Egg, Bacon
•
Turkey Soup
Southern Fried Chicken
Rice
Squash
Lettuce and Egg Salad
Jellied Prune Whip
•
Chicken Noodle Soup
Shepherd's Pie With
Biscuit Topping
Tomato Salad
Fresh Strawberries,
Cookie

30

Apricot Nectar
Scrambled Eggs
•
Creamed Asparagus Soup
Broiled Perch
Boiled Potatoes
Frozen Peas
Fruit Salad
Ice Cream
•
Tomato Soup
Toasted Cheese Sandwich
French Cut Beans
Cottage Cheese Salad
Angel Food Cake

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How To Keep Linen Control in Line

A catalog of standard linen items and preprinted inventory and requisition forms are the basis for operating this linen control system used at Miners Memorial Hospitals

Leonard Sudhalter

A BED sheet is born in a mill. Its life span is not precisely known. Condemned and unmourned, it dies in a housekeeper's office, but is reborn as two dozen assorted cleaning rags.

A new sheet is purchased by a hospital for cash, then placed on a shelf in a linen storage room until needed. The new sheet represents about $2 on the inventory records.

After this sheet goes into circulation, where is it? No one knows. Somewhere this cash investment floats elusively from distributor to user to laundry in an almost endless cycle. The cycle ultimately ends, but seldom does anyone know precisely where or when.

What Linen Control Is

Many hospitals do try to track down linens in circulation, account for them, make certain enough but not too many are in use. They also try to keep the linens in usable condition and maintain some kind of records of the length of use as well as cost of purchase.

From these efforts has evolved the term "linen control," a useful label except that it means different things to different people. Those unfamiliar with the many linen service problems in hospitals today might conclude that linen control means making sure that no one gets too much of anything. An eminent laundry consultant has said that "linen control is a well-worn phrase describing nothing . . . the linen is cotton and control is what they 'ain't got.'"

As a basis for discussion, the following working definition of linen control is suggested.

A method, or set of methods, developed by a hospital to provide:

1. Circulation within the hospital of clean, usable, required linens adequate for efficient care of the hospital's patients, so that they are where and when needed, with a minimum of paper work and handling by distributors and users.

2. A reasonable measure of accountability for the hospital linens, through a system of easily and inexpensively maintained records, beginning with the purchase and receipt of the item and ending with its condemnation or loss.

3. A reasonably accurate knowledge of the hospital's cost of linen usage and replacement to assist the administration in controlling unreasonable usage or in upgrading usage standards, with an awareness of the cost of such efforts and to assist administration in budgeting for linen usage and replacement.

This definition of linen control raises a series of questions. Will it work? Is it worth while? Do the benefits outweigh the efforts required? Is this a realistic approach to furthering administrative efforts in hospitals to control operating costs while assuring a high quality of patient care? In short, is linen control in hospitals a necessary administrative tool or a pleasant but unrealistic myth?

A well planned and executed linen control program, developed by the individual hospital organization, in terms of its own specific situation, and utilized to the full extent possible, will work, is worth while, provides benefits that far outweigh the efforts required, and is a realistic approach to efficient linen service, quality control, and usage and replacement cost control. A reasonable and efficient linen control program is a must for hospitals.

Guides Can Be Developed

Almost a truism of hospital operation is that the problems of individual hospitals differ in detail, so that no fixed rule or set of rules apply for all. However, usually a set of guides can be developed which are general enough in scope and flexible enough in detail so that they can be adapted to most individual situations.

The Miners Memorial Hospital Association has instituted a linen control program in each of its 10 hospitals. The basic plan is the same for all 10, yet, even in an integrated program, individual problems require special and separate attention. Dif-

Mr. Sudhalter is administrative assistant, business services, Miners Memorial Hospital Association, Washington, D.C.

Adapted from a paper presented at the Institute for Hospital Engineers and Laundry Managers, sponsored by the Council on Plant Operation and Plant Maintenance of the Kentucky Hospital Association, Lexington, Nov. 4, 1960.

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. . . . . By . . Dunham-Bush

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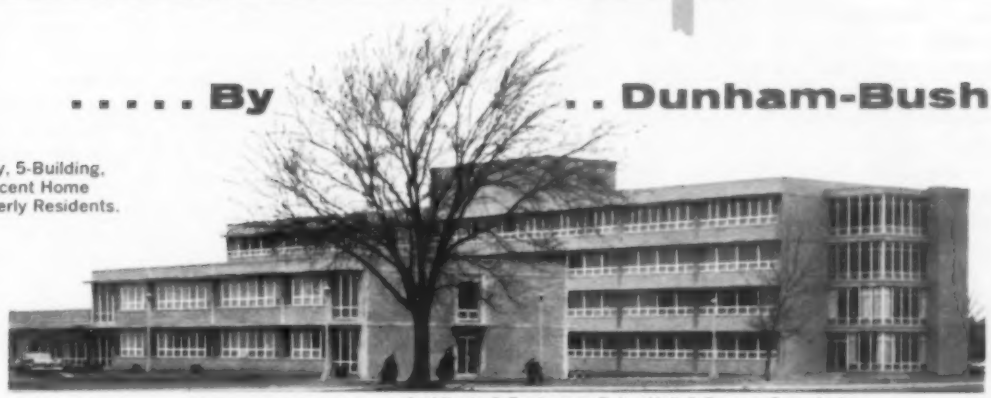

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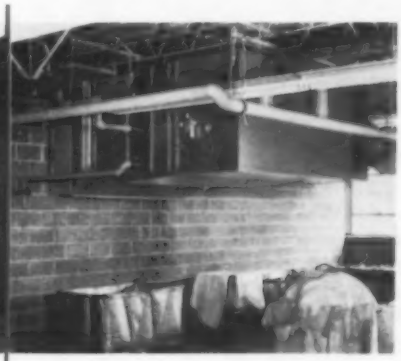
Corridor showing Dunham-Bush Radiation.



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ferences arise from variations in the types of patients served, the provision of certain specialist services in some of the hospitals, and variation in approach and attitude on the part of personnel directly involved in linen service.

The association contracts with local commercial companies for its laundry services. This affects linen control procedures to the extent that the cooperation of the commercial laundries is essential in conducting circulating linen inventories and in mending the linens. However, the basic program is adaptable to a hospital operated laundry situation with few modifications.

The methods proposed in this paper are those employed or being instituted by the Miners Memorial Hospital Association.

Linen Standardization

The first question is: What linens are required? A standard list of linens required for use in the hospital should be developed by a linen standardization committee. To be most effective the committee should be small, but should include representatives of major linen using departments. The linen coordinator should also be a member of the committee, as should the administrator or his representative.

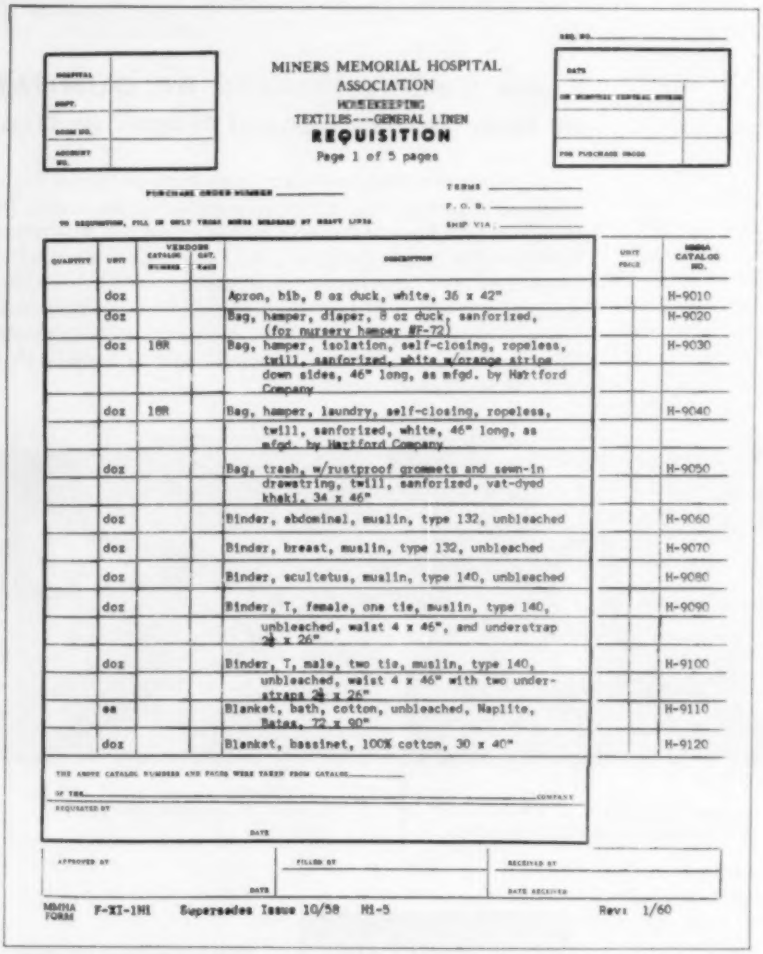
The result of the linen standardization committee's initial efforts should be a catalog of standard linens listing all linen items approved for use in the hospital, properly classified as to type, and clearly and specifically described as to nomenclature, construction, size, color and so forth.

The Miners Memorial Hospital Association's catalog assigns an identifying association catalog number to each item and indicates a unit for requisitioning purposes. The same lithographic plate used for printing the catalog is used to prepare preprinted requisitions for use by the hospitals (Exhibit 1). To requisition new linens, the hospitals need only fill in the correct quantities, and have the requisition approved and forwarded to the central purchasing service.

The terminology for each item in the standard catalog is important. And it is important that all personnel involved in linen usage, control and purchasing use the standard terminology whenever referring to a linen item. The benefits of standard terminology are particularly evident when circulating linen inventories are taken and when departmental linen requirements are discussed. It assures that everyone involved is talking about the same item. Without standard terminology, for example, several towels, distinctively different in size, shape or texture, may be called by the same name or, perhaps, the same towel called by several different names.

The initial work of the standardization committee is arduous. Duplications must be eliminated, but all needed items must be accounted for. Colors and sizes, where necessary, must be provided, but unnecessary variations in color and size must be avoided. Specifications must be developed for complicated items to assure necessary quality and durability. Conversely, decisions must be made at times to downgrade quality, as in the case of washcloths, where durability is relatively unimportant, in view of the rate of disappearance. Studies must be made to provide items of special need, which are not readily available on the market. Special color coding, as perhaps in the case of operating room linens, must be provided. Unnecessary special departmental identifications or marking should be avoided in favor of pooling as much linen as possible for common use.

The committee has a continuing



MINERS MEMORIAL HOSPITAL ASSOCIATION
HOUSEKEEPING
TEXTILES---GENERAL LINEN
REQUISITION
Page 1 of 5 pages

HOSPITAL
DEPT.
ROOM NO.
ACCOUNT NO.

REQ. NO.
DATE
FOR HOSPITAL CENTRAL BUREAU
FOR PURCHASE ORDER

PURCHASE ORDER NUMBER
TERMS
F. O. B.
SHIP VIA
TO REQUISITION, FILL IN ONLY THOSE ITEMS MARKED BY HEAVY LINES

QUANTITY	UNIT	VENDORS CATALOG NUMBER	CAT. PAGE	DESCRIPTION	UNIT PRICE	MMHA CATALOG NO.
	doz			Apron, bib, 8 oz duck, white, 36 x 42"		H-9010
	doz			Bag, hamper, diaper, 8 oz duck, sanforized, (for nursery hamper #F-72)		H-9020
	doz	18R		Bag, hamper, isolation, self-closing, ropeless, twill, sanforized, white w/orange stripe down sides, 46" long, as mfgd. by Hartford Company		H-9030
	doz	18R		Bag, hamper, laundry, self-closing, ropeless, twill, sanforized, white, 46" long, as mfgd. by Hartford Company		H-9040
	doz			Bag, trash, w/rustproof grommets and sewn-in drawstring, twill, sanforized, vat-dyed khaki, 34 x 46"		H-9050
	doz			Binder, abdominal, muslin, type 132, unbleached		H-9060
	doz			Binder, breast, muslin, type 132, unbleached		H-9070
	doz			Binder, scultetus, muslin, type 140, unbleached		H-9080
	doz			Binder, T, female, one tie, muslin, type 140, unbleached, waist 4 x 46", and understrap 2½ x 26"		H-9090
	doz			Binder, T, male, two tie, muslin, type 140, unbleached, waist 4 x 46" with two understraps 2½ x 26"		H-9100
	ea			Blanket, bath, cotton, unbleached, Naplite, Batea, 72 x 90"		H-9110
	doz			Blanket, bassinet, 100% cotton, 30 x 40"		H-9120

THE ABOVE CATALOG NUMBERS AND PAGES WERE TAKEN FROM CATALOG
OF THE COMPANY
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MMHA FORM F-XI-1HI Supersedes Issue 10/58 HI-5 Revs 1/60

Exhibit 1 is one page from printed requisition for purchase of new linens, which is prepared from the association's catalog of standard linen items.

responsibility to review the catalog for obsolescence or inadequacy due to changes in technic, and to consider requests for new items.

The catalog of standard linens forms the basis for all other linen control forms.

Linen Coordinator Is Needed

A linen coordinator is needed to coordinate all linen control planning and procedures. He is responsible for developing a sound and efficient linen control program, for following through all procedures, and for solving interdepartmental linen problems. This must be done in cooperation with all linen processing, distributing and using departments.

Who makes the best linen coordinator? Some think that this responsibility is best placed with the laundry manager, some the housekeeper. In the Miners Memorial Hospitals, the storekeeper is linen coordinator, since stores is responsible for linen storage and distribution.

Determine Quantities Needed

After a catalog of standard linens has been prepared and a linen coordinator is functioning, the next step is to determine what quantity of each item is adequate for circulation in the hospital.

The average quantity of each item needed by the entire hospital for a specific period of time must be determined as nearly as possible. This can be done by determining the average needs of each linen using department for a 24 hour period. At best, the first compilation is a guess, but a beginning must be made somewhere. The linen coordinator must consult with key personnel in each department, helping them to "guesstimate" their needs. It is possible to monitor issues and balances on hand, but this measures actual usage and not necessarily requirements. A true review of 24 hour departmental requirements includes a thorough survey of approved technics employed in daily linen use. The success of any linen control program largely depends on adherence to these approved technics by all personnel.

The total of the estimated 24 hour requirements of all departments is the 24 hour requirement for the hospital. This composite figure is multiplied by a circulation factor to determine how many of each item must be circulated in order to keep one in use. The circulation factor is based on:

1. Whether the hospital has its own laundry or is served by a commercial laundry.
2. If by a commercial laundry, how frequently pickups and deliveries are made.
3. If by its own laundry, in terms of production schedules required for economical utilization of laundry equipment and personnel.

The commercial laundries pick up and deliver linen for the Miners Memorial Hospitals three times each week. Therefore, it is necessary to have in circulation six times the 24 hour hospital requirement. This allows for two items on the way to the laundry, two on the way back, one in stores or on the linen truck, and one in use.

Hospitals operating their own laundries might use a circulation factor of four or three, depending on their production situation in the laundries.

The 24 hour hospital requirement, multiplied by the appropriate circulation factor, becomes the par for circulation.

How To Conduct Inventory

The next step should be a complete inventory of the hospital's cir-

MINERS MEMORIAL HOSPITAL ASSOCIATION

LINEN INVENTORY WORKSHEET

Sheet No. _____

Date _____ Hospital _____

Taken by _____ Dept. _____

ITEMS (General)	QTY.	ITEMS (General)	QTY.	ITEMS (General)	QTY.
APRON, Bib		MASK		TOWEL, Bath	
Tea				Huck	
		PAD, Quilted		Kitchen, blue check	
BAG, Hamper, Diaper, white, lg.				X-ray-lab, red stripe	
sml.		PAJAMA, X-large, yellow			
Isolation, yellow		Large, green			
Laundry, white		Medium, blue		WASHCLOTH	
Trash, khaki		Small, tan			
BINDER, Abd		Children, large (10-12 yrs.)			
Breast		med. (6-8 yrs.)			
Scultetus		sml. (2-4 yrs.)			
T-female					
T-male		PANTS, Training			
BLANKET, Bassinet		ROBE, Large, green			
Bath		Medium, blue			
Wool		Small, tan			
		Children, size 6			
		size 12			
CASE, Pillow, large					
small		SHEET, Bed, 72 x 108"			
		Draw, 54 x 81"			
COVER, Hot water bag		Single, 63 x 99"			
DIAPER					
GOWN, Isolation, large					
med. and sml.		SHIRT, Infant			
Patient, adult, large					
med. and sml.		SPONGE, Lap, 4 x 18"			
Infant		18 x 18"			
Large (10-12 yrs.)		8 x 36"			
Medium (6-8 yrs.)					
Small (2-4 yrs.)		SPREAD			

FORM P-XXX-21 (REV. 6-60)

(CONTINUE ON REVERSE SIDE)

Exhibit 2 shows portion of preprinted inventory worksheet that lists all the approved linen items with space for filling in the quantities on hand.

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The new cabinet's greater capacity cuts maintenance time way down. In an installation where standard Singlefold cabinets must be refilled twice a day, the new cabinet needs attention only every other day. Or one Super Singlefold will replace three standard Singlefold cabinets.

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Until now, a multi-capacity towel dispenser was impractical. Too much weight on the bottom towel prevented easy dispensing. But with this special new Fort Howard cabinet, each and every towel dispenses smoothly, without tearing—even when the cabinet is full.

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AMERICA'S MOST USED PAPER PRODUCTS AWAY FROM HOME

Preprinted worksheet makes it easier to take circulating inventory in a short time

culating linens. This is not the tremendous job it may seem. A complete linen inventory can be conducted in a hospital (as far as linen using areas are concerned) in two hours. The secret is to use efficiently, for a short time, many people already on the job.

Based on the catalog of standard linens, a preprinted linen inventory worksheet (Exhibit 2) is developed. This form lists all approved items with space for filling in quantities on hand.

A specific time is set for the circulating linen inventory and all linen using and processing departments are advised of the time well in advance. Just prior to inventory time, the worksheets are distributed to each department in the hospital, along with detailed instructions on how to conduct the count. All departments are instructed to drop all soiled linens on hand, at the time the count is to begin, into the linen chutes, uncounted.

At the appointed time, all linen chutes are sealed and the inventory begins. Usually, within two hours or less each linen using department has completed its count and the worksheets have been returned to a central point.

Separate Soiled Linen

Soiled, uncounted linens on hand at the beginning of the inventory are dispatched immediately to the laundry. This maintains a complete separation of those uncounted linens from the soiled linens which come down after the chutes are reopened at the conclusion of the count.

While the linen using departments are counting the relatively small quantities of clean linens on hand, stores (or the linen storage room, as the case may be) counts the bulk of clean linen on hand. Central sterile supply counts operating and delivery room linens on hand. The soiled, uncounted linens sent to the laundry at the start of the inventory will be counted by the laundry (if hospital owned) or by stores and central supply when returned clean, if the laundry is a commercial one. The main work of the inventory of circulating linens is concentrated in stores, central supply, and the laundry. This has its advantage in that these three departments are most familiar with the linens and with the purpose and benefits of the inventory.

Linens in Use

Several areas require special attention during circulating linen inventories. Linens in process of being mended must be accounted for, lest they appear as losses. Linens in use often are overlooked, *i.e.* scrub suits and dresses on personnel at the time of the inventory, or a drape on a patient in the ambulatory clinic. Linens in sterile trays and packs must be included in the count. A list of standard trays and packs containing or wrapped with linen should be attached to the inventory worksheet for this purpose. If the nomenclature of these trays and packs is standardized and all personnel know which is which, merely the quantity of each tray and pack on hand can be indicated by the user taking the count. This later can be broken down into components by the central supply supervisor, who is most familiar with the contents.

Inventory Report

With the first inventory completed and all worksheets turned in, the next step is to recap the circulating linen inventory and compile an inventory report. As part of this step, the departmental 24 hour requirements are listed, by department, in a separate report, and a circulating linen record book is established.

To recap the inventory, the quantities of each item from the individual worksheets are posted to a recap sheet and totaled. When all items have been recapped, the quantities are typed into a preprinted inventory report form.

To prepare the departmental 24 hour requirement report, the items and quantities estimated as a requirement for 24 hours for each department are listed on a separate page by department. This report becomes the basis for revised linen truck or closet levels.

To prepare the circulating linen record book, the par for circulation, date of inventory, and quantity in circulation are posted to a circulating linen record. A separate page is used for each item and the standard name of the item appears at the top.

Evaluate Findings

It should now be possible to review the findings contained in the inventory report and the circulating linen record book, although analyses and interpretations presently are limited by lack of experience. The only possibility, at this time, is to compare the amounts found in circulation at the first inventory with the "guesstimates" of pars for circulation. No drastic additions to, or deletions from, circulating stocks based on this limited information should be made until after a second or perhaps a third inventory. This is soon enough to draw conclusions.

However, what can be done at this point is to realign linen truck and closet levels in accordance with the newly acquired departmental 24 hour requirements. The linen using departments can be advised that, beginning with a certain date, the 24 hour requirements which they developed will be reflected in the issuances to their departments.

The linen coordinator will need to

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remain constantly on the alert for obvious deviations from the plan. Where linen truck or closet levels do not regularly deplete on a 24 hour basis, or where additional linens are regularly requested over and above those quantities agreed upon, the linen coordinator should confer with the department heads involved to determine the reasons. Technics may be reviewed to determine whether usage has increased or decreased unjustifiably. A knowledge of the patient census, surgical and obstetrical load may be enlightening. In any case, adjustments must be made either in usage or in the 24 hour issue level and, ultimately, in the par for circulation.

Second Circulating Inventory

The second circulating linen inventory should be taken not less than six months following the first. During that six-month period, accurate records are maintained in the circulating linen record book of all items issued into circulation and all items removed from circulation and condemned. Actual issues into circulation during this first period are still "played by ear." Following the second inventory, the amounts on hand once again are posted to the circulating linen record book from the inventory report. This time, however, an accounting is made in the record of what has happened in the last six months. Issues into circulation during the period are added to the last inventory figure, from which the amount of condemnations is deducted, and a balance is shown in the record. This balance is then compared with the amount counted in the current inventory, and a minus (loss) or plus (gain) figure is posted to the adjustment column on the record sheet.

Review of experience is now called for. Minus adjustments are losses or unaccounted for depletions. Plus adjustments are gains in quantity not accounted for by issues. In either case, an inventory error or an unposted issue or condemnation can be the cause. With experience in inventories and maintenance of records, the pluses should virtually disappear. Unusual minuses should provide information on specific items requiring investigation.

When three or more inventories have been conducted and recorded, over-all experience can be reviewed and action taken accordingly.

Basic Record Is One-Time Job

It should be pointed out that the work involved in preparing the 24 hour requirements and the circulating linen record book is a one-time affair. The requirement lists must be reviewed periodically and adjustments made based on changing circumstances, but this is routine and consumes little time over long periods. The record book is permanent, requiring few hours of total time between inventory periods in posting issues and condemnations. The inventory itself, once each six months (if that is the interval found necessary), can be smooth, quick and accurate. The preparation of the inventory report and posting to the record book at the end of each period is not time consuming if preprinted report forms and efficient recapping and posting methods are used. ■

Next month will conclude the description of the linen control system at Miners Memorial Hospitals with a discussion of the linen distribution methods employed.

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How To Teach Housekeeping to Housekeepers

Introducing a series by Mildred L. Chase on Administrative Housekeeping for Institutions, an outline for study in subjects required for certification in the N.E.H.A. education program

WHO does a better job of educating housekeepers than housekeepers? Not only have many of the leading administrative housekeepers educated one another through workshops, institutes, textbooks and extension courses, they have even educated colleges and universities to the importance of providing academic training in this highly specialized field.

As long ago as 1948, Mildred F. O'Donnell, then at Mount Auburn Hospital in Cambridge, Mass., persuaded the authorities of Boston University that an evening extension course in executive housekeeping would be enthusiastically received and well worth the effort – *her* effort, for the most part. And so it proved.

Three years ago, as a result of determined prodding by Madge H. Sidney and her associates in the Puget Sound chapter of the N.E.H.A., the University of Washington in Seattle established the first four-year degree, plus internship, program in administrative housekeeping. It has already bestowed the bachelor of science degree on the first candidate, who has also completed her internship.

In the years between, and since, extension courses and institutes directed by administrative housekeepers have sprung up in various sections of the country. They are a special blessing to housekeepers in the field who are seeking to qualify for certification under the N.E.H.A.'s 15 year educational program which requires 160 hours of study in specified subjects (see chart on page 145).

One such course is "Administrative Housekeeping for Institutions," offered at Los Angeles Metropolitan College of Business under the direction of Mildred L. Chase, national president of the National Executive Housekeepers Association.

Mrs. Chase, a true believer in professional training for administrative housekeepers, hopes that many similar courses will be established in all sections of the country. To help achieve this goal as quickly as possible she has given The MODERN HOSPITAL permission to publish the manual she uses in teaching. On the introductory page of the manual Mrs. Chase explains:

"This material has been assembled as an outline for study in the subjects necessary to acquire certification in the National Executive Housekeepers Association."

In Course I, to be presented in this and succeeding issues of The MODERN HOSPITAL, a three-hour lesson on each section listed, if given by an approved instructor, would provide 54 hours of credit, Mrs. Chase points out.

With the exception of the "Introduction and Orientation to Institutional Housekeeping" (beginning on page 144), each section of Course I is literally an outline on which the instructor can base her lectures on the various subjects. The instructor may be the housekeeper of an individual hospital who uses it to train her own assistants and supervisors or (as Mrs. Chase hopes) the teacher of a course in administrative housekeeping.

When she forwarded the manual, Mrs. Chase wrote: "Perhaps publication of the manual will stimulate interest in the [N.E.H.A.] education program."

It seems a reasonable assumption. Both the outline, and the numerous charts, specifications and case studies that accompany the various sections, should prove invaluable to anyone who has even a glimmer of interest in administrative housekeeping.

Before long, universities will take over the training of administrative housekeepers. Right now, the housekeepers are still doing the biggest part of the job – and doing it remarkably well. – JANE BARTON, *associate editor.*

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What an Administrative Housekeeper Is and Does

Mildred L. Chase

How Mildred L. Chase, director of housekeeping services at Glendale Sanitarium and Hospital, Glendale, Calif., finds time to breathe, let alone carry out the innumerable assignments she has cheerfully taken on, remains a mystery to her closest friends and associates. But somehow, she manages to run her department; direct the course in administrative housekeeping at Los Angeles Metropolitan College of Business; instruct a housekeeping management class at Pepperdine College, Los Angeles; serve on committees and institute faculties too numerous to mention, and perform the duties of N.E.H.A. president — all without even puffing. Mrs. Chase reports that she started her business career in food service. When, at the request of the hospital administrator, she took on the housekeeping department as a "temporary assignment" she didn't care much for the job. Within a short time she had become so fascinated that she abandoned the food service department in favor of housekeeping — and has never looked back. Probably, she hasn't had time.

THE housekeeping department of any institution is no better than the person in charge of it. Hospital and hotel managements have discovered this fact in recent years and have come to recognize that the head of the department not only must be highly skilled in all aspects of housekeeping but, above all, must be a good administrator. Hence, in "administrative housekeeping" the emphasis is placed on the administrative function, *i.e.* the ability to assess and direct the work of employes to ensure the highest quality of service.

Management has a mental image of this director of housekeeping — perhaps we all do. Can you picture in your mind this person? You remember a hotel or hospital you have visited at some time that really stands out in your mind. Perhaps it was the inviting appearance, its cleanliness, the courteous employes, all showing that someone has done an outstanding job.

This probably means that he is progressive and current in his thinking and knows that continuing personal and staff education are the only means to keep up to date with new technics and ideas. This does not mean that he needs a college degree to be an expert in his field, where his judgments are sought and respected. This may be true some day in the future as a bachelor of science degree in housekeeping is now available. It does not even mean that he needs an exceptionally high I.Q., but it does mean that he must possess the necessary attributes of character that drive him to gain all the knowledge possible in his chosen field and apply it to become a technical expert and be endowed with the ability to accomplish the job through other people. This is the person management is seeking.

Regardless of where the education is obtained — working with a qualified administrative housekeeper, taking the four-year college course plus internship, attending short courses or extension courses — let us resolve that our education for administrative housekeeping shall be continuing.

This introduction to institutional housekeeping encompasses three major areas: qualifications, responsibilities and relationships. First, let us analyze the qualities that are required for success in administration.

QUALIFICATIONS

Leadership

Proper leadership will command respect. It was a foundry president who said farm boys make the best leaders because farm boys are used to a long day of hard work. However, it may be for another reason. Haven't you noticed that people who are good at handling animals are also good at handling people? We probably will all agree that the fact animals cannot talk helps, but whatever you do: *Lead, Do Not Drive.*

Administrative Ability. Showing aptitude, mental alertness, pleasing personality will help make a good leader. From each situation, with a new set of circumstances, a different leader will emerge.

Ambition. This does not imply ambition to succeed at any cost, but the calm approach to life that an intelligent individual with confidence in his own abilities, social and educational background would take — looking at the present and to the fu-

ture with the idea of continuously striving to improve his lot.

Intelligence. This should mean being well educated and well trained but not necessarily having a college degree behind your name or an I.Q. of 150. It is the sum total of native "know-how" which springs from an open mind unafraid to consider new problems and solutions. It can mean observation and the experience you have drawn from life.

Self-Control. It is necessary to have a tremendous amount. Some people may inherit it – others come by it quite naturally – but generally it is the simplest to just apply the Golden Rule at all times – "Do unto others as you would have others do unto you."

Self-Confidence. An abundance of this quality is also required. It can be acquired by belief in people and their ambitions, and by continual seeking for knowledge. Do not be deceived by the thought that being completely happy and enjoying your work is self-confidence. You must earn that by keeping alive and growing.

Sincerity and Loyalty. Honesty must be included to complete a threesome that is essential to a leader at all times. Loyalty is one of the finest qualities a person can possess. Not a blind loyalty that can lead to ruin but that which is strength to both parties involved. Each day some loyal employe saves his fellow man from possible embarrassment or ridicule either by saying the right word or leaving the wrong word unsaid. This cannot be bought or sold; it comes from a mutual respect of the qualities within a person. There are no qualifying factors here. As to honesty, nothing less than the best can be accepted on this score.

Organizational Ability

Utilize Manpower. That means the capacity to organize and direct a well functioning housekeeping department. Ninety per cent of the work is dealing with people, which should be done in a most efficient manner.

Set Up Schedules, Records and So On. To do this you must know your particular organization so that daily, weekly, monthly and yearly duties can be accomplished without extra expense.

Make Decisions. To have the ability to make the proper decision at the right time is something to strive for: to know when to say "yes" or "no" on the basis of a sufficient amount of either background information or experience – the proper timing of the right move in relation to the over-all objectives. Most important, the department head must not be afraid to reverse a decision when necessary. This shows real strength and something that is not peculiar to any one type of individual. Don't we all wish our "batting average" in this area were 100 per cent?

Perspective. This is being in balance, making a judgment on the basis of the merits of the case, not permitting irrelevant matters to crowd your thinking. Being calm when all about us are frenzied in the heat of a problem has a quieting effect necessary to a proper hearing for all concerned.

Ability To Work With Others

Learn To Evaluate People. This is the place to use your perspective, to evaluate workers, management, guests, tradespeople and all others with whom you might have dealings. Try not to be involved in the faults of others but concentrate only on their strong points.

Avoid Personal Friction. This is a common cause of dismissal, more than incompetence. A deep understanding of people can help avoid many personnel problems.

Right Attitude. Having the proper attitude and approach to one's job, life and surroundings is most important. The idea that the world owes

National Executive Housekeepers Association
Certificate Course

GROUP I	HOURS	RANGE
Basic social sciences		6 - 15
Sociology	2 - 5	
Psychology	2 - 5	
Economics	2 - 5	
GROUP II		26 - 75
Personnel management and human relations	15 - 50	
Communications	10 - 20	
Orientation	1 - 5	
GROUP III		25 - 70
Budgeting	2 - 10	
Records	3 - 15	
Purchasing (linens, etc.)	10 - 25	
Basic interior design	10 - 20	
GROUP IV		20 - 45
Maintenance and controls	10 - 25	
Safety and sanitation	10 - 20	
		77 - 205

1. Total number of hours required for certificate equals 160.
2. Work experience as an executive housekeeper will be accepted at the rate of seven (7) hours credit for each year worked up to the limit of eighty-four (84) hours. No credit will be given for work experience acquired more than twelve (12) years prior to application date.
3. University and college credits will be accepted at their full value providing the applicant has had the minimum number of hours required in each of the four groups.
4. Short courses, extension courses, institute and vocational training credits will be accepted providing the courses have been approved by the National Executive Housekeepers Association.

you a living, and your 40 hour a week job takes you away from your home, husband or wife, and children does not make for any kind of job satisfaction. Look forward with anticipation to each new challenge. If your job is not enjoyable, then review your life or your position and question yourself on your attitude in reference to: (1) the purpose of your institution; (2) how your position fits into the total plan; (3) how you can accomplish your goals by working through people; (4) whether you take responsibility when asked.

Sense of Humor

Ability To Meet the Unexpected. Sometimes this is a real emergency, but other times it is simply finding out what someone else has been thinking for some time. This is a quality that polishes a well poised and competent individual. Life is not all business and not all pleasure but the proper blend of both. However, knowing which is which and knowing where each has its place achieves this proper blend.

Tolerance Toward All. This could well fit under any of the foregoing headings, but it takes a real sense of humor to be tolerant sometimes with the slow, the inattentive, or the uninterested person. To be tolerant requires that we are not always ready to criticize the errors or omissions of our fellow workers. It means that in all pleasantness we review the task expected of a person and, perhaps, go over it again and again with him to make certain his understanding is complete and aligned with ours.

Super-Salesman — Teacher

Ability To Teach. All employes must be taught; the better they are trained, the less waste. As a leader, you will formulate a policy on training. You will, as a sales person, leader, teacher, be able to convey to your people the ideals and purposes underlying their jobs to accomplish the goals of the organization.

Good Communications. This calls for a great deal of skill and should always be efficient and sincere. Communications, along with our attitude, occupy a prominent place in our present-day thinking. You must delegate work and authority to accomplish all you are held responsible for. When the people have been selected to do this, you cannot assume they know all the facts. Many of our real problems are caused by poor performance of a subordinate and can probably be traced back to the supervisor because he did not give sufficient directions to assure its being well done.

Talent for Research

Learn One New Thing About Your Business Each Day. Motivation provides the incentive or drive to use our abilities. In this day and age, professional journals, films and the knowledge gained by people who are specialists are all available to us; thus, we have the privilege of gaining some new knowledge in the field regularly.

Desire To Grow. A desire to grow is really the desire to stay out of the rut by guarding against the danger of thinking that you know it all, an attitude that may keep you from getting to the top. A desire to grow will keep you progressive and current in your thinking. People with this desire can see beyond the past, the old, the tried methods and interject the new and daring. This results in better methods and presents new challenges, which you strive to meet to make your task easier.

Use Your Imagination. Management is longing for and seeking people with imagination who can see beyond the past, who do not accept on face value alone all that has gone before but use some of the brain matter with which God gave us to think.

Share Knowledge and Gain That of Others. It is necessary to exchange ideas and thoughts to keep fresh. If we do not get out and attend institutes, conventions, courses and regular meetings, the gray matter in our brains just gets grayer and grayer. Taking an active part in your professional activities will always broaden you.

Be Observant. When you take a new position, you are always full of ambition, thrilled, sometimes frightened, but you automatically absorb and soon comprehend some of the mechanics of the job. If you could just always pretend that this is a new job, so that your mind is always open to observe, you would find that *there is always an open road ahead.*

Knowledge of the Department

It is essential that the department head understand each job that is performed — and when and how it is to be done. Strive to become an expert whose judgments are sought and respected. Continue until you feel that you have achieved some success in your field, and then you will want to keep right on going to achieve some more. The housekeeper must have technical competence in the following broad areas:

Accounting. A knowledge of simple accounting is necessary to prepare budgets, if needed, make your annual reports, keep records and schedules.

Decorating. It is often necessary for the housekeeper to select colors, fabrics, carpets and furnishings, and supervise painters and upholsterers, and so forth. You should be sufficiently skillful in the use of line and color to achieve a warm atmosphere for guests.

Mechanical. A working knowledge of mechanical equipment is important so that you can discuss with engineering and maintenance departments what is wanted or needed.

Purchasing. You may not purchase directly, but with your records you can study prices, and with your experience and testing of supplies and equipment you can recommend items that give the most value for the institution's dollar.

Sanitation. A housekeeper needs to be a chemist of sorts. Without some knowledge of chemistry you could easily use the wrong cleaner or wax on expensive floor coverings. A daily portion of your work will include extermination, trash and refuse disposal, aseptic and isolation technics. This is a live field, full of new developments; it is a challenge to keep up with it.

Many more qualifications could be listed — such as neatness (certainly, a part of every housekeeper), dependability, planning and so on, but the ones listed are, perhaps, the most important. These are some of the things that management is looking for. Administrators realize that most of the qualities they want in housekeepers, short of maturity, experience and job knowledge, are already ingrained in the person.

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Suppositories **DULCOLAX®**
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the laxative that replaces the enema effectively

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Dulcolax eliminates the most unpleasant duty that nurses and ward personnel have—the routine administration of enemas. Furthermore, ward duties relative to bowel care can be completed by 9:00 or 10:00 A.M., freeing personnel for other work. And, of course, there's no enema equipment to clean.

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ter of qualifications, let us not lose sight of what is being sought — a thoroughly trained and capable administrative housekeeper who will be a credit to himself, to his employer, and to his professional organization. If you fit this prototype, you will realize this is no place to stop or even pause, but you will put emphasis on new ideas; you will continue to seek educational opportunities, and when you have obtained experience so that you are eligible, you will participate in your professional organizations.

RESPONSIBILITIES

The more you think of them, the more you are conscious of all the factors involved.

To Management

Here you are expected to think like a person of action and act like a person of thought. Proper training of departmental personnel includes:

1. Outlining job specifications and procedures — then providing proper instruction for your employes.
2. Giving information on policies and work schedules.
3. Responsibility for the attitude and ability of the department's employes.
4. Orientation in jobs other than the employes' specific assignments so that they can be a source of manpower available in the case of necessity.
5. Teaching by example.

Good Supervision of Departmental Personnel. Following adequate training, supervision will save time, materials and manpower. Management expects the housekeeper:

1. To interpret to your personnel the objectives in the achievement of common goals.
2. To have the ability to understand and work with your personnel. This is not always inherited, and many times must be developed through education, training and experience.

Cleaning — Areas Involved, Procedures, Allocating Workloads.

1. Know the area to be served.
2. Study traffic and time problems, day or night, interruptions, obstructed or unobstructed.
3. Budget allowed.
4. Manual or mechanical technics to be used.
5. Contract or limited time.
6. Standard or de luxe (luxury) service.
7. Labor conditions — overlapping with other departments.

Ordering and Purchasing Supplies.

1. Requisition
2. Check orders
3. Keep track of deliveries

Departmental Records.

1. Payroll
2. Inventories
3. Budgets
4. Requisitions
5. Schedules
6. Contract Work

Furniture and Furnishings.

1. Routine care
2. Special care
3. Future plans

To Other Departments

Building Good Morale Means:

1. Top management must develop smooth interdepartmental relations, and you have a large part in this.
2. Respect others' ability.
3. Be pleasant about constructive criticism.
4. Keep your mind open to suggestions.
5. Assume full responsibility for departmental employes.
6. Be willing to acknowledge and correct mistakes.

Harmonious Relations Mean:

1. Always apply the Golden Rule.
2. Be adaptable in meeting the unexpected.
3. Discuss common problems.
4. Listen to others' points of view.
5. Be willing to change procedures when needed to be helpful. The timing of the work of other departments often precludes the economical and efficient performance of a housekeeping department.
6. Present ideas. Yours can be as helpful to others as theirs, many times, are to you.

To Departmental Employes

Give Adequate Training and Guidance.

1. Have a sincere appreciation and understanding of the problems that confront your employes.
2. Win their confidence, faith and respect.
3. Be open-minded and have a well balanced look at all subjects.
4. Help them to obtain satisfaction from their tasks.

Be the Kind of Person Others Will Follow.

1. Be fair to all employes.
2. Give the kind of leadership that will bring good results from your efforts.

RELATIONSHIPS

With Owners or Board of Trustees. You may be responsible to management, but equal respect for those with whom your management works must be shown at all times.

With Management. If you are a close personal friend or relative, this should be forgotten during working hours. If you do not respect the manager as a person, you should not show that you don't.

With Other Department Heads. They are specialists in their line just as you are in yours; respect their abilities.

With Department Employes. It is a more generally accepted policy of good ethics to keep employes on a last name basis. Localities differ so that it is necessary to follow management's lead on this.

With Employes of Other Departments. Respect their positions and orders. Any problems should be discussed with their department head.

With Patients and Guests. The patient is always right. If it were not for him, we would not have our job. Being overly friendly, however, can lead to many problems and embarrassing situations.

With Visitors. They are our patients' relatives and friends. They should be treated with the utmost respect but must not be allowed to interfere with the welfare of the patients.

With the Community. Your name in the community can influence your position.

With Yourself. Make proper allowance for rest, food and activities away from your work. ■

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Emergency Units Inadequate, Hospital Survey Shows

(*Continued From Page* 102)

commented on this point indicate there has been no change in the number of visits to the hospital emergency room as a result of the arrangement with the medical society. Five hospitals noted a definite decrease in emergency department visits which they thought represented the response to this service. On the other hand, five hospitals stated that visits have been actually increased by the existence of a panel of physicians on call for emergency services.

Of all patients visiting the emergency departments of the hospitals surveyed, 42 per cent were considered to have nonemergency problems and 18 per cent were subsequently admitted to the hospital as inpatients, the study shows. Analysis of 29,300 emergency room visits at 197 hospitals during one week reveals that the types of cases for which emergency care was sought were: general surgery, 27 per cent; medicine, 27 per cent; pediatrics, 14 per cent; orthopedics, 14 per cent, and other, 18 per cent.

The primary conclusion to be drawn from the study, the authors indicate, is that the increasing number of visits to hospital emergency rooms (which totaled 17 million in 1958) represents a change in function of these facilities rather than a simple increase in visits for accidental injuries. Furthermore, there is a conflict between the hospitals' conception of the functions of an emergency service and that of the public: Nearly three-fourths of the hospitals still consider that emergency room services should be limited to real emergencies, whereas the public obviously looks to the hospital emergency department for medical care in a wide variety of situations.

These conflicts, the authors state, are obviously responsible for many of the problems in emergency department administration and in relations with the public. "Some of these difficulties," they conclude, "could be resolved by formulation of an acceptable definition of emergency department responsibility and function by the medical profession and the hospitals. Once the responsibilities of both of these groups have been delineated, the public should be educated in the proper use of hospital emergency facilities." ■

Hospital's Legal Duty May Extend Beyond Provision of Emergency Care

(*Continued From Page* 88)

If the nature of the patient's injury or sickness is such that hospitalization is not indicated, a duty does exist to inform the patient of any further treatment needed and to render such treatment, perhaps as an outpatient, until adequate referral can be made or there is no further danger to the patient in ceasing treatment.

With respect to billing the patient, emergency care is no different than any other hospital service. A hospital has the right to charge a reasonable fee for emergency care and to include in this fee any expenses incurred in treating the patient. If payment is not forthcoming, suit may be brought to collect the bill. It is immaterial that the care was rendered while the patient was unconscious and thus could not contract for the service. Liability for the reasonable value of the care will be implied. Similarly, a parent may be held responsible for emergency care rendered to a minor child. All that is required is that the emergency care was actually needed and that such care was not rendered despite the protest of the patient.

What of future legal problems in the area of emergency care? It is clear that patterns of community medical and hospital care are changing and that the nature of the emergency service itself is changing. When a person suffering from an emergency condition calls his physician, the physician often tells him that he will meet him at the hospital instead of going to the patient's house. Or, the physician may refer the patient to the hospital's emergency service directly. The administrative aspects of the hospital's role in such a case are just beginning to be considered. The legal problems which may be created by such changing custom are as yet unformulated.

One thing, however, is clear: The coupling of violent injury causing immediate danger to the patient's life and health with a heightened need to provide prompt efficient care makes the emergency situation one which could well result in considerable future legal problems for hospitals.

Suggested Course of Action

What course of action does this series of articles suggest for hospitals? Does the solution lie in closing the emergency room, in offering no emergency service at all, thus side-stepping the problems outlined herein? I think not. Legal problems are inherent in any activity. The most foolproof solution to hospital legal problems is to close the hospital entirely.

There may be sufficient reasons for not providing an emergency service, but the presence of legal risks is not one of them. However, the presence of legal problems constitutes a good reason not to permit inefficient or discriminatory emergency service.

It is not within the province of this article to weigh the personnel or financial considerations inherent in a decision regarding emergency care, but it can be stated that such care can be provided without undue legal risks to the institution if potential legal problems are recognized and provided for.

It is considerably better that a hospital provide adequate emergency care voluntarily, as a result of a felt duty to the community, rather than be forced to do so under rigidly prescribed conditions by statute, public pressure, or the courts. ■

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The Modern Hospital News Digest

Interns Find Their Match; N.I.M.P. Places More Than 6600 of Them in 814 Hospitals

The buttons have been pushed, the cards punched, the results published. For this year's June class of medical school graduates, as well as for the 814 hospitals participating in the National Intern Matching Program, the suspense is over. As in the past, nearly as many internships went unfilled as were filled. The 1961 totals: 6637 internships filled; 6049 internships unfilled; 328 unmatched students.

Dr. Ward Darley, executive secretary of the program, indicated that this year's effort helped confirm three trends: (1) increased stipends are no sure way to attract interns; (2) hospitals closely affiliated with medical schools have the easiest time filling their quotas, and (3) students increasingly favor straight internships in medicine and surgery over rotating internships. ■

Conventions Dot Nation's Landscape; Spring Health Field Meetings Now in Full Bloom

Along with the turtle, the voice of the convention speaker was heard across the land this spring. Here are reports of what the voice was saying at health field meetings in March and April.

Both Sides Accused of 'Misleading' Public on Social Security Plan for Aged Medical Care

While hospital experts were trying to clarify the issue of medical care of the aged before convention groups around the country, the leading proponents and opponents of the current proposal were busy accusing each other of "misleading" the public on how the social security method of financing would work — or not work. ***(Page 165)***

Hospital Right to Private Decision Subject to Public Needs, Trustees Advised

PITTSBURGH. — "Long-range planning cannot prevent change, but it can help take the chance out of it." So saying, Ray E. Brown, administrator of University of Chicago Clinics, set the tone for a hospital planning institute for trustees here March 15.

So demanding is the hospital's responsibility to plan, he claimed, that the hospital does not have the right to private decision in matters relating to adequacy and continuity of service. "The individual hospital is not free to pick and choose the services it provides the community, but is obligated to use its unique resources for all the medical needs of the community that require such resources," Mr. Brown stated.

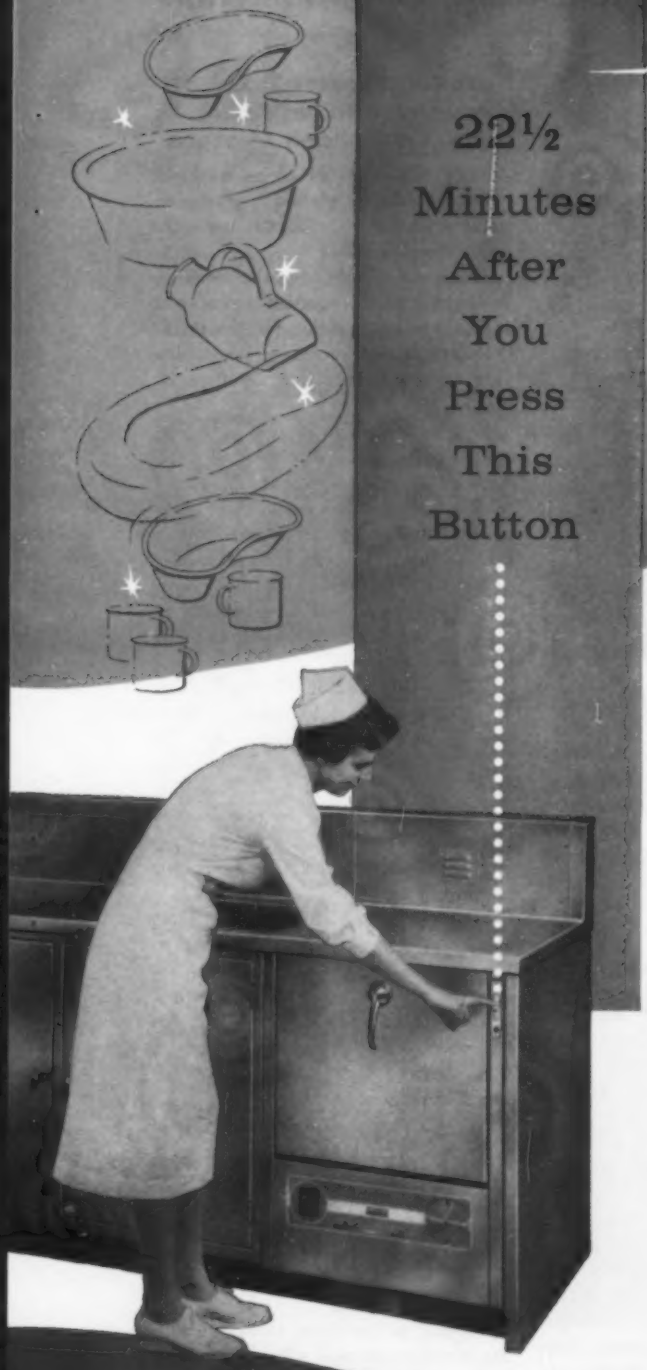
Raymond P. Sloan, trustee of Memorial Hospital for Cancer and Allied Diseases, New York, drove the point home for trustees, who comprised nearly half of the 300 registrants.

"Any action taken by trustees, administrators, medical staff members, or groups without critical appraisal of its purpose and need in the overall community health patterns is in direct violation of competent stewardship," he said.

Development of regional medical centers providing for a wide spectrum of services and facilities on a common site was envisioned as the long-range objective of hospital planners by Dr. Jack C. Haldeman, assistant surgeon general of the U.S. Public Health Service.

"In such a complex," he said, "services and facilities will be made available for all types of patients and would (1) provide for better utilization of scarce professional and technical personnel, and (2) permit a more flexible use of facilities as medical advances result in changes in the character of the institutional population."

Fifty-five hospitals in Western Pennsylvania were represented at the meeting.



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Sounds of Spring Fill the Air – and the Convention Halls

Shown above are new officers elected by the New England Hospital Assembly. They are, left to right (seated): president-elect, Norman R. Brown; president, Elmina L. Snow, R.N.; trustee, the Rev. Stephen K. Callahan, secretary to the bishop for hospitals, Providence, R.I. Standing: trustees, Vernon L. Ballard, Portsmouth Hospital, Portsmouth, N.H.; Isidore S. Geetter, M.D., Mount Sinai Hospital, Hartford, Conn.; Joel H. Walker, Barre City Hospital, Barre, Vt., and John L. Quigley, Soldiers Home, Chelsea, Mass.

Trustee Institute on 'Use and Misuse' Draws Crowds at New England Hospital Assembly

BOSTON. – The trustee institutes, long regarded as a special attraction of the New England Hospital Assembly, lived up to their reputation at the assembly's 40th annual meeting here March 20 to 22.

For example, the session entitled "The Use and Misuse of Hospitals" drew an overflow audience to hear Walter J. McNerney, director of the hospital administration program at the University of Michigan, describe a study of overutilization in Michigan.

Mr. McNerney pointed out that $10 million could have been saved in the state in 1958 if there had not been overstays of patients and, to a lesser extent, if fewer diagonstic procedures had been done.

He noted the survey showed that overstays amounted to 10 per cent of all admissions and that those understaying accounted for 7 per cent.

Reporting on another aspect of the utilization problem, Robert Sigmond, executive director of the Hospital Council of Western Pennsylvania, noted that 25 per cent of all the hospital beds in the country are empty at all times and that in Pittsburgh half of all pediatric beds are always empty.

Underuse was called a greater misuse than overuse by Dr. Edwin L. Crosby, executive vice president of the American Hospital Association. Underuse is bad health care, he said, while overuse is inefficient, costly and can be bad medicine.

The trustees didn't steal the whole

(*Continued on Page* 162)

Hospital Officials Take 'Craven Stand' on Aged Issue, Cruikshank Charges

KANSAS CITY, MO. – Social security advocates played proponents of the voluntary way here last month.

Neither side won.

The contest was over the issue of health care of the aged. It was staged at the annual meeting of the Mid-West Hospital Association, which this year attracted more than 3000 registrants.

First to tee off in earnest was Nelson Cruikshank, director of the A.F.L.-C.I.O. department of social security. Mr. Cruikshank, long recognized as one of the hardest hitters in the social security camp, swung hard at the "craven stand many hospital spokesmen feel it necessary to take on the issue of health benefits for America's aged."

Tearing up a divot, Mr. Cruikshank attacked opposition to President Kennedy's health care program for the aged as "the most flagrant evidence of the extent to which some hospitals are out of tune with the people they are designed to serve, and with the community to which they look for support."

When representatives of hospitals speak out against health benefits to the aged financed through social security, he asked, "whom are they speaking for? They do not speak for the people of their community and I don't believe they speak in the interest of their hospitals."

Mr. Cruikshank characterized the recently enacted Kerr-Mills Act as a supplementary program that meets the needs of only a small segment of the aged – "those already in dire need who happen to live also in a state where matching money has been appropriated."

Playing in the same twosome with Mr. Cruikshank was Albert Spradling Jr., president pro tem of the Missouri senate. Mr. Spradling winced at the thought of more money and power heading toward the federal government, as would be the case if the health needs of the aged were financed by social security.

(*Continued on Page* 166)

at Regional and State Hospital Meetings Around the Country

Southeastern Hospital Conference Stresses Role of Hospitals in Preserving American Freedom

MEMPHIS, TENN. — Delegates to the Southeastern Hospital Conference here April 19 to 21 took a day off from consideration of the worries of the hospital to contemplate the greater worry of the Communist threat to the American world of free enterprise, including the voluntary hospital system.

This departure from traditional convention programing was planned, according to Pat N. Groner, administrator of Baptist Hospital, Pensacola, Fla., because "while many people think it is not the hospitals' business, preservation of our rights is everybody's business and we have not been paying attention to our responsibilities as American citizens."

Mr. Groner's views were echoed by William E. Smith, executive director of the Hospital Industries Association, who pointed out that the convention's theme — "Americanism" — was wholly appropriate inasmuch as "democratic principles are under tremendous pressure and voluntary hospitals are one of the bulwarks of the democratic system."

The three speakers at the opening session were Dr. Kenneth D. Wells, president, Freedom Foundation, Valley Forge, Pa.; Dr. Clifton I. Ganus, vice president and dean of the School of American Studies, Harding College, Searcy, Ark., and Karl Hess, director of information services, Champion Paper and Fibre Co., Hamilton, Ohio. All three warned the audience that communism has not only encircled the United States but moved in on it in sundry guises, and urged the members to take an active part in "exporting our own Revolution," as Mr. Hess phrased it, and in providing leadership that the world can truly believe in.

Although the Wednesday afternoon speakers left some doubt as to whether America has much of a future, the Southeastern convention planners were optimistic enough to schedule a session on "Preparing Hospital Personnel for the Future." Panelists at this session represented the trustees, administration, nursing service, and nursing education.

The trustee, S. B. Wise of Clarksdale, Miss., with fine impartiality, spanked doctors, administrators and trustees for their shortcomings, though his hand was heaviest when he dealt with the trustees. "Medical staffs," said Mr. Wise, "are so well organized they forget they are a part of the hospital team. They have tended to leave the teamwork to the administrator. As a result, communications have broken down and it's the patient who suffers."

Of the administrator (whom he described as "neither fish nor fowl but he has to be both — and I feel sorry for the poor guy"), Mr. Wise said: "He has so many problems he is likely to lose sight of what his job is — and I'll bet there isn't an administrator in this room who doesn't agree."

The kind of trustee who "tries to

(*Continued on Page* 164)

'Right to Good Health' — How To Finance It, Topics at Ohio Hospital Association Meeting

COLUMBUS, OHIO. — Good health has become an inalienable right of every American, delegates at the Ohio Hospital Association convention were told, but how to pay for it is still very much a question.

The view that good health has been added to food, clothing and shelter as "an inalienable right of an American" was expressed by Robert E. Toomey, director of Greenville General Hospital, Greenville, N.C. The problems of financing health care, for those unable to pay for it themselves, were debated by two speakers representing government and the American Medical Association points of view.

New officers of the Ohio Hospital Association are, left to right, seated: Edgar Mansfield, first vice president; Sister Eugene Marie, S.C., president-elect; Harold Zealley, president; and, standing, Richard Athey, second vice president, and Lee Lanpher, treasurer. Mr. Mansfield and Mr. Lanpher were reelected to their positions.

The Administration's bill to provide medical care for the aged was branded as "unnecessary, unsound and inequitable" by William J. McAuliffe Jr. of the A.M.A.'s law department. Defending the social security approach as the best technic for providing prepaid insurance was Sidney Spector, staff director of the Senate subcommittee on problems of the aged, who helped write both the Administration bill and the broader McNamara bill.

The association named as president-elect Sister Eugene Marie, S.C., administrator of Good Samaritan Hospital, Cincinnati. Harold A. Zealley, administrator of Elyria Memorial Hospital, Elyria, succeeds John C. Gettman, administrator of Memorial Hospital, Fremont, as president.

Other officers for the coming year are: first vice president, Edgar O. Mansfield, superintendent, White Cross Hospital, Columbus; second vice president, Richard H. Athey, administrator, Newark Hospital, Newark, and treasurer, Lee S. Lanpher, administrator, Lutheran Hospital, Cleveland.

The convention, held here April 3 to 6, drew approximately 3000 persons representing 240 Ohio hospitals.

Dear Hospital Administrator:

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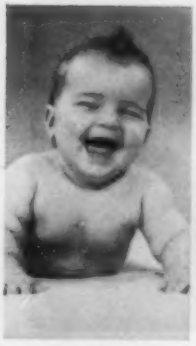


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Computers May Take the Guesswork Out of Hospital Planning, Carolinas-Virginias Told

ROANOKE, VA. — A quarter-million or so details, mathematically organized, may take the guesswork out of hospital planning in the future, James J. Souder, New York architect who is study director of the A.H.A.-A.I.A. research project on planning, suggested here last month at the 31st annual Carolinas-Virginias hospital conference.

Mr. Souder said that A.H.A.-A.I.A. investigators had accumulated 250,000 separate data in their observations of nursing units, central supply service, radiology and pharmacy departments in two hospitals.

Hospital planning in the past has been based too largely on "a wide spectrum of viewpoints and almost no facts," Mr. Souder said.

To organize facts and thus provide a means of measuring the validity of the judgments that are freely rendered by hospital planners, Mr. Souder reported, the investigators recorded seven kinds of observation in the hospital departments studied. These were: (1) who came to the department, (2) when the person came, (3) where he came from, (4) how he came, (5) what he brought with him, (6) how he carried it, and (7) what was the purpose of the visit.

The data thus accumulated total approximately 250,000 items, Mr. Souder said. With the use of computers, he added, it is hoped that data can be organized in a way that may lead to the introduction of new planning methods. "The intuitive approach is a luxury we can no longer afford," he concluded.

Demands for public investigation of hospital organization and, especially, hospital costs represent an opportunity for administrators and recognition of the important role of administration in health care, Ray E. Brown, superintendent of the University of Chicago Clinics, told the conference.

"At last someone is looking at us," Mr. Brown said. "We have our chance at bat."

Administrators should not be discouraged or dismayed by the fact that hospitals have been blamed for rising medical costs, Mr. Brown said. "We have our opportunity now to show what we are doing," he explained. In the past, he pointed out, the public was interested only in the clinical and scientific side of the hospital. "Nobody paid any attention to administration, so there was no reason to evaluate our service," he said.

In the future, the heat will be increasingly on administrators, and the public will demand effective organization of hospital facilities and personnel, Mr. Brown concluded. "This is recognition for the administrator," he said.

Dr. Jack Masur, assistant surgeon general of the U. S. Public Health Service and A.H.A. president-elect, reported that medical research programs are conducted in 850 hospitals, or one in eight institutions, in the United States today. Nevertheless, he said, research is hampered by a shortage of personnel, facilities and money.

Joseph E. Barnes, administrator of Rex Hospital, Raleigh, N.C., presided at the conference, which drew an attendance of 1900 hospital workers from the four states. Esther Touchberry, superintendent of Marion Sims Memorial Hospital, Lancaster, S.C., is president-elect of the conference.

U.S. Mortality Rate Drops 50 per Cent Since 1900

NEW YORK. — The mortality rate in the United States has been cut nearly in half in the last 60 years, according to the Health Information Foundation.

In 1900, the death rate, the best available measure of a nation's health level, was 17.2 per 1000 persons, the foundation reported. The 1960 rate was only 9.5 per 1000.

Mortality declined for every age group with the younger age group, especially children, showing the greatest improvement. The rate has dropped by 82 per cent during infancy and by 94 per cent at ages one to four.

Death rates have dropped more rapidly for females than for males since the turn of the century, the foundation reported. However, unlike the widening sex differential, the mortality differential between the white and the nonwhite population has narrowed, statistics showed.

Hospitals, Newspapers Both Unappreciated, Editor Tells Meeting of Georgia Hospitals

ATLANTA. — Hospitals and newspapers have at least one thing in common — they are both unappreciated, the editor of the *Atlanta Constitution* ruefully acknowledged here last month.

The editor, Eugene Patterson, spoke at the opening session of the annual meeting of the Georgia Hospital Association.

The association met concurrently with the Georgia Association of Hospital Governing Boards. Registration totaled 395, a record for the meeting.

"Like newspapermen," Mr. Patterson said, "hospitals hear most from people who like them least."

If hospitals could do something to improve the operation of their emergency rooms — "and I think they can," he added, they will do much to improve the public's impression of hospitals.

A warning about the dangers of administrative complacency in the area of personnel policies was provided by Kirk M. McAlpin, a Savannah attorney. Unions thrive on complacent managers, he pointed out, because such managers are always behind in their comprehension of employe unrest.

Supporting Mr. McAlpin's views, Jack Owen of the American Hospital Association staff warned the audience that "unions have only one thing to sell — management mistakes."

In official actions, the G.H.A. urged that the governor find current surplus revenues to implement the Kerr-Mills program for the state's indigent aged beginning with the next fiscal year.

The association also reaffirmed its resolution of a year ago, when it advised state agencies which purchase hospital care in various programs that, after July 1, G.H.A. member hospitals would no longer be able to service such programs at less than actual average per diem cost at any one hospital. The hospitals have resolved to terminate contracts with the agencies unless relief is forthcoming this year, stating that private pay patients can no longer be asked to subsidize indigent care.

Officers elected at the two-day meeting included: president, Arthur T. Stewart Jr., administrator, Minnie G. Boswell Memorial Hospital, Greensboro; president-elect, Owen B. Hardy, administrator, Phoebe Putney Memorial Hospital, Albany, and secretary-treasurer, Thomas B. Wolfe Jr., administrator, Polk General Hospital, Cedartown, Ga.

N.Y. Council Opposes Plan To Enlarge Bellevue

NEW YORK. — A plan to rebuild Bellevue Hospital, adding 1642 general care beds to the lower Manhattan municipal hospital, has been criticized by the Hospital Council of Greater New York.

Thomas J. Ross, president of the council, said that the approved plans for rebuilding Bellevue call for 342 more beds than will be needed. In a letter to Dr. Ray Trussell, commissioner of hospitals, Mr. Ross pointed out that a 1956 study estimated that 1300 additional general care beds would be needed in lower Manhattan in 1965.

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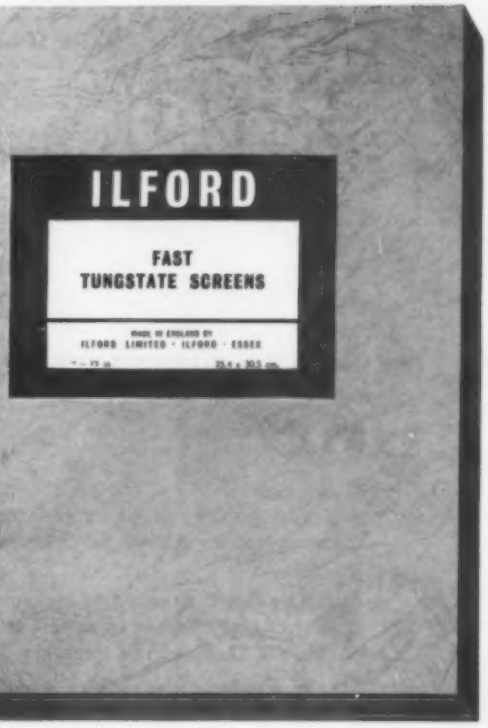

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New England Assembly

(*Continued From Page* 156)

show, however; the session on hospital management and unions attracted a great deal of attention not only from the registrants, but also from the Boston newspapers.

Richard T. Viguers, administrator of Boston's Pratt Clinic-New England Center Hospital, told the group that while New England is not faced with any strong drive for unionization of hospitals at the present time, "the situation may change any day.

"This is the very time we should put our houses in order. Now is the time for us to adopt fair, wise and forward-looking personnel policies."

One speaker took exception to this view that better conditions would discourage union organization.

Better conditions, said Frederic C. LeRocker, director of the Sloan Institute of Hospital Administration at Cornell, will attract a new breed of hospital employe who may insist that he have a voice in his working situation.

Hospitals recognize the need for public relations, one public relations director said, but "are trying to attain a successful program for a multi-billion dollar business with a 35 cent budget and are not even getting full value for that." The only answer, continued Edward M. Friedlander, public relations director of Pratt Clinic-New England Center Hospital, Boston, is a more professional approach.

At the session on new advances in patient care, Dr. Dwight Harken, surgeon at Boston's Peter Bent Brigham Hospital, referring to the current use of mechanical aids such as heart-lung oxygenators and artificial kidneys during surgery, predicted permanent replacement of such organs within another decade or so.

Norman R. Brown was named president-elect of the assembly. He is administrator of Concord Hospital, Concord Mass. He will succeed another Concord administrator, Elmina L. Snow, administrator of Emerson Hospital there, who is the new president.

Other new officers are: treasurer, Pearl R. Fisher, R.N., administrator of Thayer Hospital, Waterville, Me., and secretary, Horace F. Altman, administrator of Robert Breck Brigham Hospital, Boston.

Southeastern Conference

(*Continued From Page* 157)

bask in the sunlight of public esteem by lending his name to an institution, shows up at the hospital for half an hour or an hour a month, and second-guesses everything the administrator tries to do," is not worthy of his trust, in Mr. Wise's view. In Mississippi, he reported, 308 hospital trustees have formed an Association of Hospital Governing Boards (of which he is secretary-treasurer) so that the administrators will have someone to speak for them in the state legislature. "I would say to trustees that if you will band together you will lend weight to hospitals and state associations and perhaps be able to curb the idea that hospital and medical care costs must rise," he concluded.

Dr. David B. Wilson's ideas on how to prepare personnel for the future included paying better wages to more highly skilled workers and doing a much better job of training.

Dr. Wilson, director of the University Hospital, Jackson, Miss., warned that "we cannot expect to continue to operate with low-income, low-level workers. We'll get just what we pay for." He contended that hospitals must expect to pay reasonably well and expect that their employes will be reasonably well trained. Because training programs are so important, Dr. Wilson recommended that they be developed around hospital councils or state associations.

The two representatives of nursing, Nina Mae Basham, director of nurses at Baptist Memorial Hospital, Memphis, Tenn., and Laurene Gilmore, assistant director, nursing education, Birmingham Baptist Hospital, Birmingham, Ala., agreed that nursing service of today and tomorrow is nothing like the nursing service of yesterday — and it's not going to be. Furthermore, Mrs. Gilmore asserted, the people who want to go back to the "good old days" of nursing would be sorry if they got sick and had to depend on old-fashioned methods of nursing because "You'd be dead." The nurse of yesterday just couldn't do the things that are required of present-day nurses, she said. Mrs. Gilmore summed up the difference between nursing service and nursing education thus: "Nursing service employs the nurse of today and yesterday while nursing education prepares the nurse of tomorrow."

(*Continued on Next Page*)

At the business session, delegates named Raymond B. Wilson, administrator of Baptist Hospital, New Orleans, president-elect, and Robert A. Ivy, Doster Hospital and Clinic, Columbus, Miss., trustee-at-large for a three-year term. E. E. Cavaleri Jr., administrator, "365" Crippled Children's Clinic and Hospital, Birmingham, Ala., assumed the presidency of the conference at the Friday morning session, succeeding Gene Kidd, administrator, Baptist Hospital, Nashville, Tenn.

Registration at the meeting was expected to total 1500.

H.I.A. Awards

Awards for the best technical exhibits, presented jointly by the Southeastern Hospital Conference and the Hospital Industries Association, were presented during the meeting.

Winners in the single-booth category were:

First prize: Carrom Industries, Ludington, Mich.

Honorable mention: Sterilon Corporation, Buffalo, N.Y.

In the multiple-booth category, winners were:

First prize: Hill-Rom Company, Batesville, Ind.

Honorable mention: Royal Metal Manufacturing Co., New York.

Insurance Actuary Claims Public Being Misled About Social Security Financing

CHICAGO. — The American Medical Association has brought in an insurance actuary to back up its claims that social security isn't the right method of financing health care for the aged.

The insurance man's contention is that comparisons of social security financing with voluntary private insurance are inaccurate and have misled the public.

Writing in the April 8 issue of the *Journal of the A.M.A.*, Ray M. Peterson, vice president and associate actuary of the Equitable Life Assurance Society of the United States, declared that:

1. The public is being given the false impression that the method of financing the social security program possesses many of the unique characteristics of voluntary private insurance which the people have learned to value highly.

2. The program has been misrepresented as being a "time tested" and "tried and proved" system of financing old-age benefits.

3. The people are being given the mistaken impression that social security benefits are paid out of accumulated reserves, similar to private insurance programs, when in truth the program is financed almost entirely on a pay-as-you-go basis with benefits paid out of current income.

Mr. Peterson cited figures which he said showed that "with no reserve fund in sight to reduce the debt," created under the social security program, "the burden being passed on to future generations is permanent. It is not something that will somehow work itself out, or go away; it is not an actuarial fantasy."

He said that adding medical care to the social security system for the present aged would alter the original concept that each person must contribute for a minimum period of time before he is entitled to benefits.

The A.M.A. also found itself on the other side of a charge of "misleading" last month. In a television interview, H.E.W. Secretary Abraham A. Ribicoff said "the A.M.A. is getting panicky" and is misleading the public in its advertising campaign aimed at defeating the government sponsored medical care program.

Secretary Ribicoff cited a poster which he said the A.M.A. had distributed to physicians for display in their offices. The poster is misleading, he said, in suggesting that patients would not be permitted to choose their doctors and that doctors would be paid and controlled by the government under the social security program.

The A.M.A. came right back and accused Secretary Ribicoff of making "false and misleading statements" about the organization's purposes.

Dr. F. J. L. Blasingame, executive vice president of the A.M.A., replied to Mr. Ribicoff's charge and accused him of "political trickery when he claims the King bill is not socialized medicine."

"Any program which calls for compulsory health care which is controlled and regulated by the federal government is socialized medicine for that segment of the population which it serves," the A.M.A. official continued.

Midwest Meeting

(*Continued From Page* 156)

Spraying his shots, he urged hospitals to present patients with an explanation of health care costs as well as a bill. State legislators are especially responsive to the wishes of the people they serve, and, he warned, "I fear growing demand on the part of people for the regulation of hospital costs."

The state senator said Missouri will not pass legislation implementing the Kerr-Mills Act this year because of lack of funds to pay its cost.

Shooting for the pin, Frank Groner, president of the American Hospital Association, put A.H.A. back in the game at the next general session.

A.H.A., he said, opposes use of the social security mechanism to finance care of the aged. The primary concern of the government in such a program, he said, would be its cost, with quality of care coming in second.

Moreover, he pointed out, there is little chance of retraction once such a program is started.

"It's hard to get back to the springboard once you enter the water," he warned.

The wide variances in estimating the cost of the program also troubled Mr. Groner. If the costs turn out to be much higher than anticipated, hospitals — not the government — will get the blame, he said.

Later, a foundation president and a Blue Cross official condemned "irresponsible talk about overutilization."

Hospital administrators and authorities who should know better have fostered this kind of talk, admonished George Bugbee, president, Health Information Foundation. Assessing a recent study in Maryland, in which three out of four physicians said facilities are being overutilized, Mr. Bugbee said he wasn't convinced that the physicians knew exactly what they meant by overutilization. While there are some abuses, he maintained, they are not a significant factor in the rising cost of hospital care (for other views on overutilization, see page 156.

Supporting Mr. Bugbee, N. D. Helland, executive director, Oklahoma Blue Cross-Blue Shield, complained that "we are not going to get anywhere by pussyfooting around and generalizing about these abuses." The thing to do, he suggested, is to pin down such charges wherever they occur and "then the clowns who write editorials will have to look someplace else for their stories."

In official business at the meeting, Carl Lamley, executive director, Stormont-Vail Hospital, Topeka, Kan., was named president-elect.

New York Nurses Now Empowered To Perform Intravenous Procedures

NEW YORK. — Registered nurses will be permitted to perform intravenous procedures under a new reinterpretation of New York law.

In discussing the ruling by Attorney General Louis J. Lefkowitz, the Medical Society of the State of New York called on physicians and hospitals to make certain nurses are thoroughly familiar with the latest intravenous technics.

A 1942 ruling had interpreted any puncturing of the skin as a medical act to be performed only by a physician.

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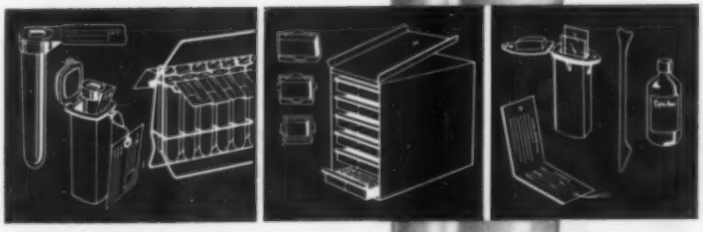

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Laboratories Exploited, Pathologist Tells A.A.H.C.

(*Continued From Page 76*)

chief of the nursing department, National Institutes of Health. She said the study thus far showed there were three and a half to four hours a day during which "a non-nurse person" could relieve the head nurse of administrative details.

Dr. Robert M. Farrier, assistant director of the Clinical Center, described the "electronic nurse," an instrument still in the experimental stage, which measures temperature, blood pressure and respiratory rate of surgical and medical care patients. He said it worked adequately on the fairly healthy patient, who understood its purpose, and the very sick patient, who lay inert and did not care, but it was not so expert with the in-between patient who, in his state of fogginess, often tended to push away the instrument.

An ad hoc committee to study fee schedules charged by members of the Association, under the chairmanship of Dr. J. Russell Clark of Sayville, Long Island, N. Y., met to review the preliminary reports received from members. The full report will be ready for the annual meeting in September in Atlantic City. ■

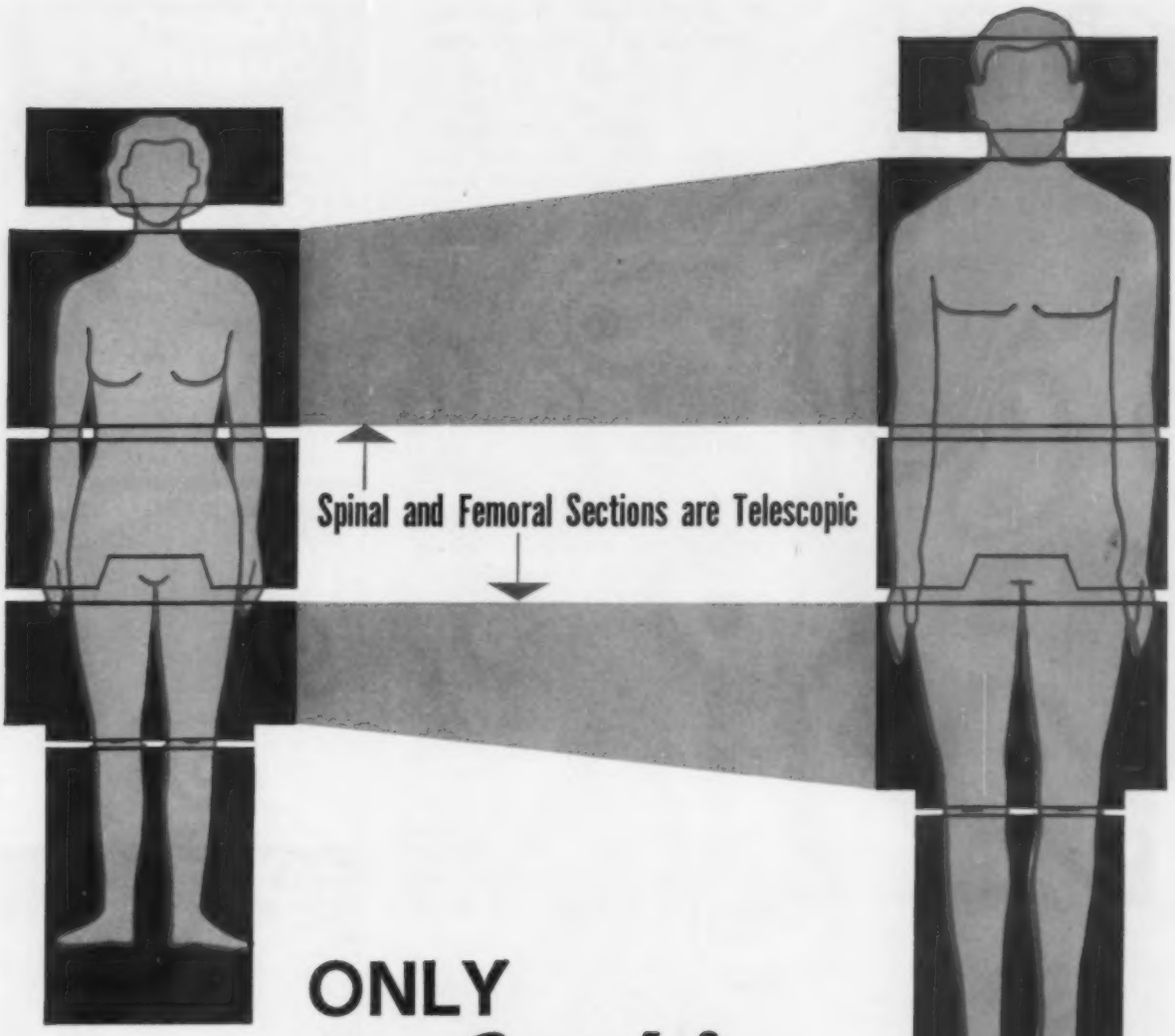
Use of Obstetrical Care Increases; So Does Cost

NEW YORK. — More expectant mothers are using obstetrical health services although the price for this care has risen sharply.

A survey conducted by the Health Information Foundation and the National Opinion Research Center of the University of Chicago showed that average maternity care costs increased more than 40 per cent between 1953 and 1958.

During 1957-58, women who had a live birth sought medical care earlier in pregnancy and used more physicians' services than did a comparable group five years earlier, the report said. Relatively more of these confinements were medically attended and took place in hospitals; in this period average length of hospital stay per confinement, however, was shorter than in 1953.

The national bill for maternity services was estimated at $1,150,000,000 in 1957-58, an increase of more than 50 per cent in five years.



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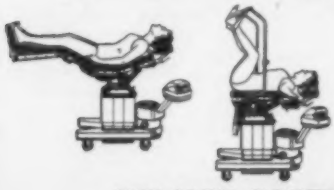

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Michigan Court Overturns Charitable Immunity Rule

LANSING, MICH. — "Today charity is big business," the supreme court of Michigan acknowledged in overthrowing the doctrine of immunity of charitable institutions from liability.

As a result, it held the Port Huron Hospital, Port Huron, Mich., liable for the death of a patient resulting from negligence of one of the hospital's employes. (Parker v. Port Huron Hospital, 105 N.W. 2d 1, Mich.)

In announcing the new ruling, the court said: "The old rule of charitable immunity was justified in its time, on its own facts. Today we have a new set of facts . . . described by old nomenclature. To say that the old rule of law still applies is to reach a result on the basis of nomenclature, not of fact; it is to apply a rule, proper in its time, to completely new facts, and to justify doing so by reference to language merely without regard to the facts."

Commenting on the big business character of modern charity, the court said:

"It often is corporate, both in the identity of the donor and in the identity of the donee who administers the charity. Tax deductions sometimes make it actually profitable for donors to give to charity."

In holding the Port Huron Hospital liable, the court was careful to point out that, in light of the reliance which some charitable, nonprofit hospital corporations may have placed on the old rule and because they may have failed to protect themselves by insurance, the new rule would apply only to the case before the court and to all future actions rising after the date of the ruling.

Texas Issues New Rules for Interns, Residents

DALLAS. — New rules for the certifying of interns and residents have been issued by the Texas Board of Medical Examiners and approved by the Texas Hospital Association.

The new rules provide for interns and residents to be issued permits from the state board, which will be automatically canceled if the intern or resident uses his permit to practice outside the designated hospital or terminates his internship or residency for reason other than illness.

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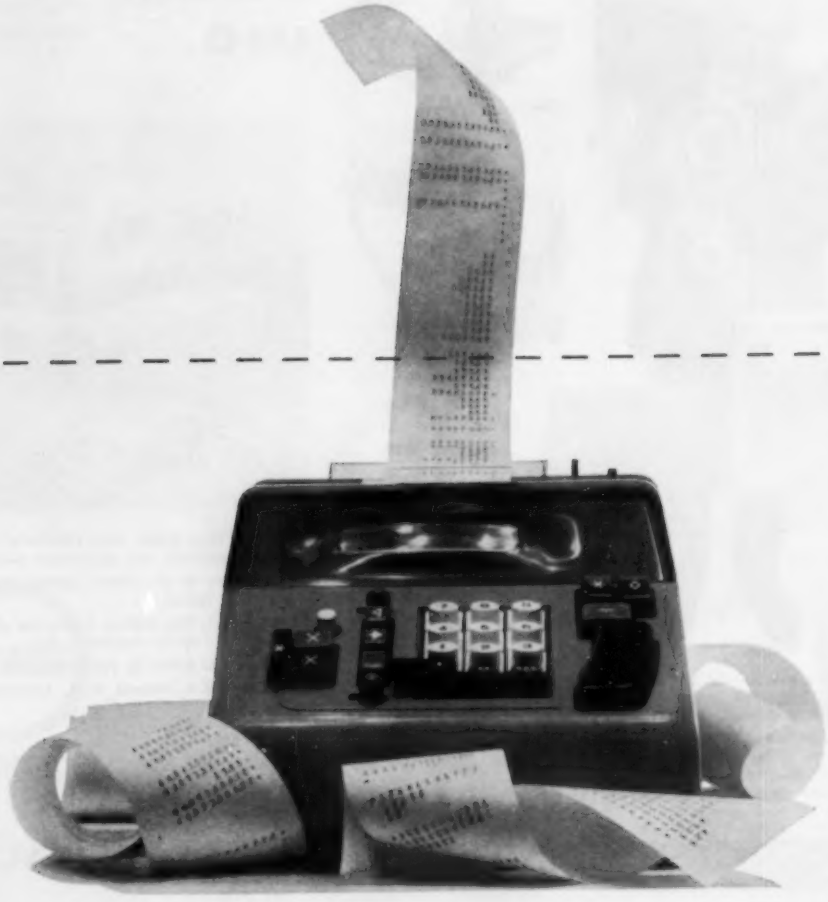

COMING EVENTS

AMERICAN ASSOCIATION OF BLOOD BANKS, Drake Hotel, Chicago, Oct. 25-28.

AMERICAN ASSOCIATION OF HOSPITAL ACCOUNTANTS, Annual Institute, Indiana Univ., Bloomington, July 16-21.

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS, Convention Hall, Atlantic City, Sept. 25-28.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Convocation, Convention Hall, Atlantic City, Sept. 24.

AMERICAN COLLEGE OF SURGEONS, Conrad Hilton Hotel, Chicago, Oct. 2-6.

AMERICAN HOSPITAL ASSOCIATION, Annual Convention, Convention Hall, Atlantic City, Sept. 25-28.

AMERICAN MEDICAL ASSOCIATION, annual meeting, Coliseum, New York, June 26-30.

AMERICAN PHYSICAL THERAPY ASSOCIATION, Palmer House, Chicago, July 2-7.

AMERICAN PUBLIC HEALTH ASSOCIATION, Cobo Hall, Detroit, Nov. 13-17.

AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS, Olympic Hotel, Seattle, Sept. 29-Oct. 8.

AMERICAN SOCIETY OF MEDICAL TECHNOLOGISTS, Olympic Hotel, Seattle, June 11-16.

ARKANSAS HOSPITAL ASSOCIATION, Arlington Hotel, Hot Springs, May 29-31.

CATHOLIC HOSPITAL ASSOCIATION, Civic Auditorium, Detroit, June 12-15.

COLLEGE OF AMERICAN PATHOLOGISTS, Seattle, October 1-7.

CONNECTICUT HOSPITAL ASSOCIATION, Berlin, June 14.

COMITE DES HOPITAUX DU QUEBEC, Montreal Show Mart Inc., Montreal, Que., June 26-28.

HOSPITAL ASSOCIATION OF NEW YORK STATE, Atlantic City, May 17-19.

HOSPITAL ASSOCIATION OF PENNSYLVANIA, Penn Harris Hotel, Harrisburg, Oct. 17, 18.

HOSPITAL ASSOCIATION OF RHODE ISLAND, Sheraton-Biltmore Hotel, Providence, Oct. 10.

IDAHO HOSPITAL ASSOCIATION, Elks Lodge, Boise, Oct. 16, 17.

INTERNATIONAL HOSPITAL FEDERATION, Venice, Italy, June 5-9.

MAINE HOSPITAL ASSOCIATION, Samoset Hotel, Rockland, June 6, 7.

MARITIME HOSPITAL ASSOCIATION, Nova Scotian Hotel, Halifax, N.S., June 5-8.

MARYLAND-D.C. HOSPITAL ASSOCIATION, Shoreham Hotel, Washington, Nov. 8-10.

MICHIGAN HOSPITAL ASSOCIATION, Hotel Pantlind, Grand Rapids, June 18-20.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, May 17-19.

MISSISSIPPI HOSPITAL ASSOCIATION, Hotel Buena Vista, Biloxi, July 12-14.

MONTANA HOSPITAL ASSOCIATION, East Glacier Hotel, East Glacier Park, Sept. 7, 8.

NEW HAMPSHIRE HOSPITAL ASSOCIATION, Wentworth-by-the-Sea, Newcastle, June 1, 2.

NEW MEXICO HOSPITAL ASSOCIATION, Albuquerque, May 17-19.

NORTH CAROLINA HOSPITAL ASSOCIATION, Grove Park Inn, Asheville, June 21-23.

OKLAHOMA HOSPITAL ASSOCIATION, Mayo Hotel, Tulsa, Nov. 2, 3.

TENNESSEE HOSPITAL ASSOCIATION, Riverside Hotel, Gatlinburg, May 25, 26.

TEXAS HOSPITAL ASSOCIATION, Statler-Hilton, Dallas, May 14-17.

THIRD WORLD CONGRESS OF PSYCHIATRY, Montreal, Que., June 4-10.

Detroit Hospital Signs

DETROIT. — Nonprofessional employes at Burton Mercy Hospital here are now covered by a one-year contract negotiated by the A.F.L.-C.I.O. The agreement reportedly includes a 10 cent per hour across-the-board wage increase and the establishment of a 90 cent hourly minimum.

The contract affects approximately 116 employes.

ABOUT PEOPLE

(*Continued From Page* 104)

William Erickson has succeeded **Robert Hanson** as administrator of Auburn General Hospital, Auburn, Wash. Mr. Hanson is now in charge of Maynard and Riverton hospitals, Seattle.

C. E. Hendricks is the new administrator of Memorial Hospital, Perry, Okla., succeeding **George Hart,** who has accepted a similar position at Cordell Memorial Hospital, Cordell, Okla. Mr. Hendricks was formerly administrator of Sayre Municipal Hospital, Sayre, Okla.

Mike W. Ditto, former business manager of Arlington Memorial Hospital, Arlington, Tex., has been named administrator of that hospital. He succeeds **Ruth Bruenig,** who died in February.

Eual Baker has resigned as administrator of Memorial Community Hospital, Wautoma, Wis., to become administrator of Shawnee Mission Hospital, Kansas City, Kan.

Frank H. Silversides has resigned as administrator, Cornwall General Hospital, Cornwall, Ont., to be executive director of the Health Association of the Hudson Bay Mining Company, Flin Flon, Manit. **Kenneth S. McLaren** is the new administrator at Cornwall. Previously Mr. McLaren was assistant professor in hospital administration, University of Toronto School of Hygiene.

Morris London has joined the staff of Jefferson Medical College Hospital, Philadelphia, as an assistant director. He had previously been research associate of the Hospital Council of Western Pennsylvania. Prior to that Mr. London was administrative director at Jewish Hospital, Cincinnati. He is a graduate of the Yale University program in hospital administration.

Morris London

Millard L. Wear has resigned as administrator of Kennestone Hospital, Marietta, Ga. Mr. Wear is a professor of hospital administration at Georgia State College, is a member of the American College of Hospital Administrators, and is a past president of the Georgia Hospital Association.

Nina Stansell, business manager and administrator of Curry General Hospital, Gold Beach, Ore., has resigned to go into private business.

Martha F. VanWert is the new executive director of Children's Country Home, Westfield, N.J., succeeding **Mrs. Harry A. Kniffin.** Before going to Children's, Miss VanWert was assistant director of Elliot Community Hospital, Keene, N.M.

Stanley H. Wilkins has resigned as administrator, Memorial Hospital, Bowmanville, Ont. His successor is **Bernard Holden,** former administrator of Deep River Hospital, Deep River, Ont.

S. Ames Pence is the administrator of the new Tri-City Hospital, Oceanside, Calif., which will open June 1. Previously, he was administrator of Marin General Hospital, San Rafael, Calif. Mr. Pence holds a master's degree in hospital administration from the University of California.

A. J. Williamson is now administrator of Pleasant Valley Hospital, Point Pleasant, W.Va. He was formerly administrator of Berger Hospital, Circleville, Ohio.

(*Continued on Page* 180)

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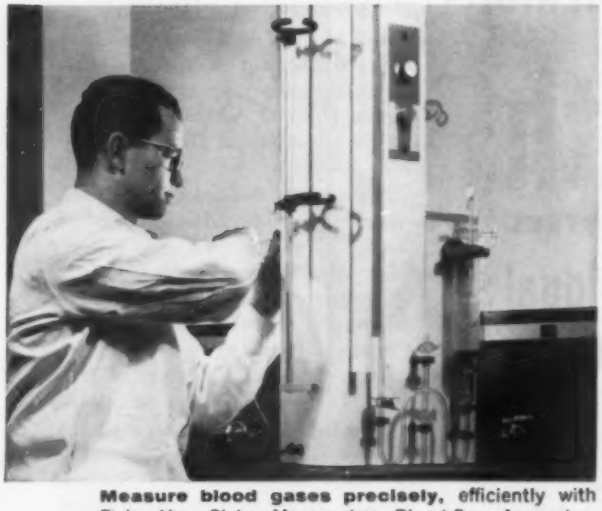

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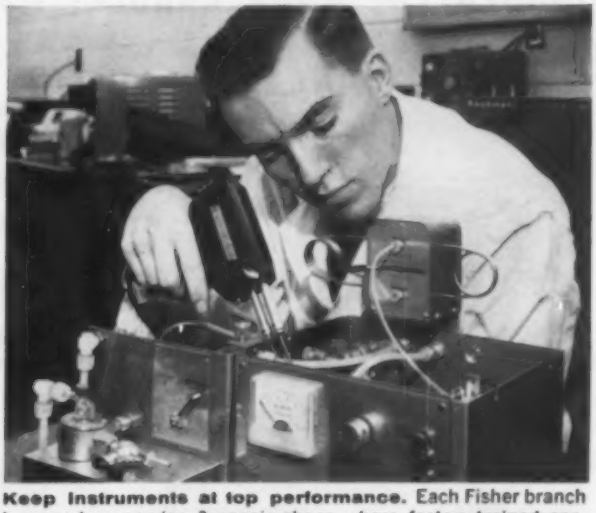

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(*Continued From Page* 176)

Donald F. Zuercher has been named administrator of Glendale Northwest Hospital, Glendale, Ariz. He was previously acting administrator of War Memorial Hospital, Sault St. Marie, Mich. Mr. Zuercher received his master's degree in hospital administration from the University of Minnesota.

Mrs. R. McKenzie, formerly director of nurses, has been appointed administrator, Milton District Hospital, Milton, Ont. She succeeds **Don McCallum,** who resigned.

Dwain E. Brown has been appointed assistant administrator and business manager of Ivinson Memorial Hospital, Laramie, Wyo.

Fred W. Molgren has been named administrator of Broken Bow Community Hospital, Broken Bow, Neb. Previously, he was administrator of Lutheran Hospital, Sioux Center, Iowa.

Edgar P. Furie has resigned as administrative director of Jewish Hospital, Cincinnati, to become assistant administrator at Gottleib Memorial Hospital, Oak Park, Ill.

Dr. James R. McShane has been elected medical director of Reading Hospital, West Reading, Pa. He has been acting medical director since the death of **Dr. Clair G. Spangler** last November.

Arthur O. Stout has been appointed assistant administrator of Brockton Hospital, Brockton, Mass. Mr. Stout is a graduate of the army hospital administrative school at Baylor University, and has recently retired from the medical service corps of the army with the rank of Lieutenant Colonel. Mr. Stout holds membership in the American Hospital Association, American College of Hospital Administrators, and the Royal Society of Health of England.

Arthur O. Stout

Thomas J. Broderick has been named assistant administrator of Marin General Hospital, San Rafael, Calif. Mr. Broderick was formerly administrator of Jay County Memorial Hospital, Portland, Ind. He holds a master's degree in hospital administration from the University of Chicago.

Jack L. Samuels has been named assistant director of Mount Sinai Hospital, Milwaukee. Mr. Samuels received his master's degree in hospital administration from Northwestern University.

K. C. Abernethy has been named assistant administrator of Washington Township Hospital, Fremont, Calif. He has been business manager of the hospital since August 1960. Mr. Abernethy received his master's degree in hospital administration from the University of California at Berkeley, and completed his administrative residency at San Diego County General Hospital, San Diego, Calif., and the Donald N. Sharp Memorial Community Hospital, San Diego, Calif.

K. C. Abernethy

Ray M. Trippe has been appointed administrator of Gadsden County Hospital, Quincy, Fla. He has been acting administrator of the hospital for five months.

(*Continued on Page* 182)

objective:

full term fetus

complication:

threatened abortion

indicated:

Provera

Upjohn

Here are five reasons why:

- Provera is the only commercially-available oral progestational agent that will maintain pregnancy in critical tests in ovariectomized animals.
- It is four times as potent (by castrate assay) as any other progestational agent.
- No significant side effects have been encountered.
- It is available for both oral and parenteral administration
- Provera gives the economy of effective action from small doses.

Brief Basic Information

	● Oral Provera*	I.M. Depo-Provera**
Description	Upjohn brand of medroxyprogesterone acetate.	Aqueous suspension, 50 mg. Provera per cc., for intramuscular injection only.
Indications	Threatened and habitual abortion, infertility, dysmenorrhea, secondary amenorrhea, premenstrual tension, functional uterine bleeding.	Threatened and habitual abortion, endometriosis.
Dosage Threatened abortion	10 to 30 mg. daily until acute symptoms subside.	50 mg. I. M. daily while symptoms are present, followed by 50 mg. weekly through 1st trimester, or until fetal viability is evident.
Habitual abortion		
1st trim.	10 mg. daily.	50 mg. I.M. weekly.
2nd trim.	20 mg. daily.	100 mg. I.M. q. 2 wks.
3rd trim.	40 mg. daily, through 8th month.	100 mg. I.M. q. 2 wks. through 8th month.
Supplied:	2.5 mg. scored, pink tablets, bottles of 25; 10 mg. scored, white tablets, bottles of 25 and 100.	Sterile aqueous suspension for intramuscular use only. 50 mg. per cc., in 1 cc. and 5 cc. vials.†

Precautions: Clinically, Provera is well tolerated. No significant untoward effects have been reported. Animal studies show that Provera possesses adrenocorticoid-like activity. While such adrenocorticoid action has not been observed in human subjects, patients receiving large doses of Provera continuously for prolonged periods should be observed closely. Likewise, large doses of Provera have been found to produce some instances of female fetal masculinization in animals. Although this has not occurred in human beings, the possibility of such an effect, particularly with large doses over a long period of time, should be considered.

Provera, administered alone or in combination with estrogens, should not be employed in patients with abnormal uterine bleeding until a definite diagnosis has been established and the possibility of genital malignancy has been eliminated.

†Each cc. of Depo-Provera contains: Medroxyprogesterone acetate, 50 mg.; Polyethylene glycol 4000, 29.8 mg.; Polysorbate 80, 1.92 mg.; Sodium chloride, 8.65 mg.; Methylparaben, 1.73 mg.; Propylparaben, 0.19 mg.; Water for injection, q.s.

The Upjohn Company, Kalamazoo, Michigan

*TRADEMARK, REG. U.S. PAT. OFF. **TRADEMARK

(*Continued From Page* 180)

David M. Hatfield has become assistant administrator at Decatur and Macon County Hospital, Decatur, Ill. He was formerly an administrative assistant at the University of Chicago Clinics, Chicago.

Donald M. Honeywell has been appointed administrator of Bacon County Hospital, Alma, Ga.

Marjorie J. Johnson, administrator of Presbyterian Hospital, Newark, N.J., retired May 1. She had been with the hospital for the last 36 years. Miss Johnson was named assistant administrator of the hospital in 1938 and administrator in 1948.

Daniel N. Finch has been named administrator of Bronson Methodist Hospital, Kalamazoo, Mich. He was administrator of Bucyrus Community Hospital, Bucyrus, Ohio. Mr. Finch succeeds the late **Dr. William C. Perdew.**

Department Heads

Edith Sears Cox has been named director of medical social service succeeding **Dorothy McNulty** at Passavant Memorial Hospital, Chicago.

George H. Toler has been named director of the purchasing and issuance department at Jewish Hospital, Cincinnati, succeeding **Nettie S. Margileth,** who retired.

Lewis Jefferson has been employed as accounting supervisor at Audrain Hospital, Mexico, Mo. He had been office manager of Lincoln County Memorial Hospital, Troy, Mo., for the last four years.

Josephine L. McConnell has been appointed director of nursing service at Firmin Desloge Hospital of St. Louis University, St. Louis. Miss McConnell received her master of science degree in nursing education from St. Louis University.

Doris Gaskins, R.N., has been appointed director of nursing at Greenwood Leflore Hospital, Greenwood, Miss. She is a graduate of the school of nursing at Methodist Hospital, Memphis, Tenn., where she has served for the last five years as assistant director of nursing service.

Vivian Warren, R.N., has assumed the post of operating room supervisor at California Hospital, Los Angeles. She was formerly with White Memorial Hospital, Los Angeles.

Anna TeKampe is the new director of nursing service at Memorial Hospital, Casper, Wyo. Miss TeKampe was formerly associate-director of nursing at Colorado General Hospital, Denver. At the same time it was announced that **Jane Talbert** had been appointed chief dietitian at Memorial.

Margaret McLaren has been appointed director of nursing service, Louise Marshall Hospital, Mount Forest, Ont.

Albert P. Freije succeeded **Alfred H. Marshall** as director of public relations at Grace-New Haven Community Hospital, New Haven, Conn.

Violet Camblin has been named director of nursing, Ross Memorial Hospital, Lindsay, Ont.

Clara Donaszewski has been named director of nurses, **Joseph M. Matakovich,** maintenance coordinator, and **James G. Russell,** controller, at Cloverleaf Hospital, North Miami Beach.

Doris Harris has been named personnel director of Missouri Baptist Hospital, St. Louis.

Bernadette Legris has been named director of nursing, Winchester District Memorial Hospital, Winchester, Ont.

(*Continued on Page* 185)

NEW CONCEPTS FOR MODERN PATIENT CARE

Pre-packaged Trays

PHARMASEAL LABORATORIES • GLENDALE, CALIFORNIA

(*Continued From Page* 182)

Dr. James T. Lester Jr. has accepted the post of director of psychological services, Orthopaedic Hospital, Los Angeles.

Virginia Springgate has been appointed to the newly created post of director of volunteers at Temple University Hospital, Philadelphia.

Julian Pike has been named food service manager of Peninsula General Hospital, Edgemere, N.Y.

David N. Martin is the new chief pharmacist at Hartford Hospital, Hartford, Conn., succeeding **Mrs. J. H. Somers.** Mr. Martin formerly was pharmacy supervisor at Massachusetts General Hospital, Boston.

Miscellaneous

Patricia Brandt, R.N., has been named an assistant director of the division of nursing, department of professional services, of the American Hospital Association. She has been a professor of nursing at the University of Arkansas' school of nursing since 1958. At the same time the A.H.A. announced that two persons have joined the staff in the Washington service bureau. They are **Selma M. Levine** as legal counsel to the bureau and **Lacey Clinton Sharp** as an adviser in legislative matters.

Dr. Harry E. Walkup, chief of surgical service and assistant director of professional services for research at the Oteen, N.C., Veterans Administration Hospital, has been appointed the V.A.'s assistant director of surgical service in the Washington office. At the same time it was announced that **Dr. Harold W. Schnaper** of Mount Alto Veterans Administration Hospital, Washington, D.C., has been appointed to the newly created post of chief of research in internal medicine for the V.A. in Washington.

Dr. C. Alpheus Stanfield has been appointed associate director of graduate education at Highland Hospital, Rochester, N.Y., succeeding **Dr. Richard Saunders,** who has been named associate dean of Cornell Medical College.

W. Glenn Ebersole, former executive director of the Hospital Council of Southern California, has accepted the post of executive director of the Hospital Council of Hawaii.

Deaths

Dr. Elmer Hess, 71, president of the American Medical Association in 1954 and 1955, died March 29.

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Vina-Lux® 800 Series

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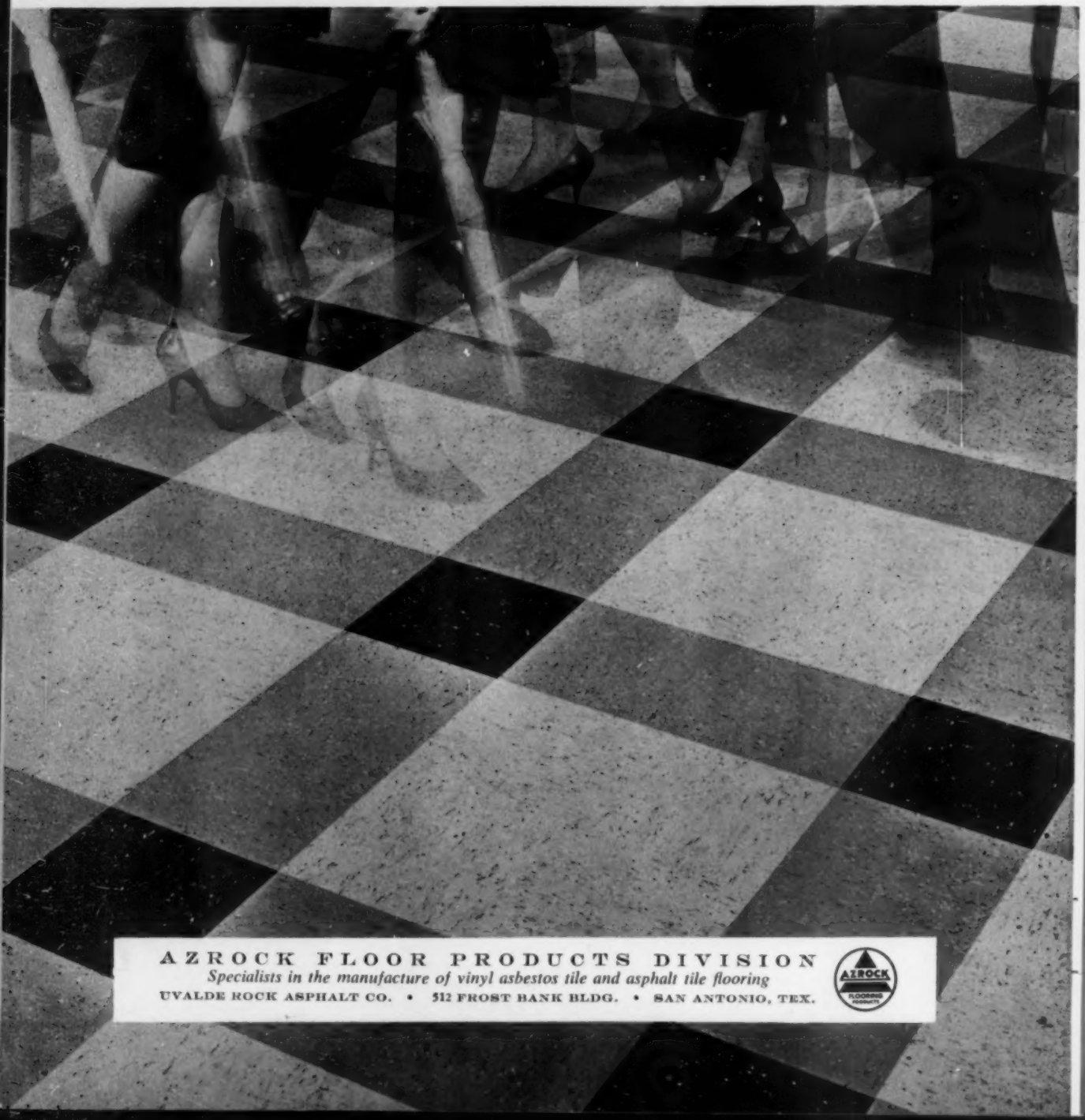

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POSITIONS WANTED

ADMINISTRATOR—Experienced; college degree and professional registration; age 44; prefers East Coast. Write to MW 99, The MODERN HOSPITAL.

ADMINISTRATOR—R.N.; age 41; B.S. degree in Administration, 4 years assistant administrator in 150-bed hospital; has had 16 years extensive experience in all phases of administration, including, personnel accounting, nursing service, construction program, and fund raising; excellent references, prefers hospital of 100-beds or less. Write to MW 101, The MODERN HOSPITAL.

ANESTHETISTS—Certified registered nurse; Two (2) female; experienced in all types and modern techniques of anesthesia; desire opportunity to take charge of anesthesia department in small community hospital somewhere in midwest or western states; either on free-lance or salaried basis, references; Write to MW 102, The MODERN HOSPITAL.

DIETITIAN—(not ADA) with 19 years of institutional and commercial experience desires to relocate; prefers south. Write to MW 100, The MODERN HOSPITAL.

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

Telephone DElaware 7-1050

900 N. MICHIGAN AVENUE, CHICAGO

ADMINISTRATOR—34 years old; 9 years experience, assistant administrator, purchasing, 300-bed hospital; wishes 100-bed hospital, midwest.

ASSISTANT ADMINISTRATOR—M.S.H.A. Northwestern University; 4 years experience, administrative assistant and personnel director, 400-bed hospital; 31 years old; wishes relocate Indiana, Illinois, Wisconsin.

ADMINISTRATOR—M.S. Hospital Administration, Columbia University; 4 years experience assistant administrator 900-bed hospital; 3 years assistant 300-bed hospital; 37 years old; wishes position as administrator 200-bed hospital, New England.

FOOD SERVICE DIRECTOR—B.S. Accounting; 10 years experience hospital management, menu planning; record proves ability run efficient department with great savings.

CONTROLLER—C.P.A.; 5 years experience 350-bed hospital; wishes relocate Washington, D.C. area.

MALE ANESTHETIST—Excellent experience all agents; wishes free lance opportunity; any location.

CHIEF DIETITIAN—A.D.A.; 10 years experience, excellent references; wishes university hospital, any location.

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185 N. Wabash—Chicago, Ill.

Founders of the counseling service to the medical profession serving medicine with distinction over half a century.

ADMINISTRATOR—40; M B A; M S H A; Member A.C.H.A.; past 5 years, director, 200-bed general; seeks administration, larger progressive hospital; outstanding man.

ASSISTANT ADMINISTRATORS—(a) 28; BA; MHA; FAHA; 2 years, assistant director of administration, then administrative resident, medical college hospital; 3 years director, 50-bed general. (b) 45: RN; BS; MSHA; 4 years experience administrative posts at large hospitals; 8 years admitting officer, 700-bed unit.

ANESTHESIOLOGIST—35; AOA; 1 year, anesthesiologist, with a large group; passed part I; FACA; seeks hospital post.

PATHOLOGIST—University trained; exceptional experience; since '56, chief 350-bed; Diplomate, both branches, CP and AP.

RADIOLOGIST—45; Certified in diagnostic, therapeutic and nuclear; 10 years assistant director of radiology, large hospital; seeks directorship.

INTERSTATE MEDICAL PERSONNEL BUREAU
Miss Elsie Day, Director
332 Bulkley Building
Cleveland 15, Ohio

ADMINISTRATOR—A.B. Degree; Master's Degree in Hospital Administration; 4 years experience assistant administrator, large eastern hospital; present position 6 years, administrator 60-bed hospital; desires change.

ADMINISTRATOR—Or assistant; B.S. Degree; Major: Business Administration; 4 years personnel director; 5 years assistant director, 500-bed Ohio hospital.

ASSISTANT ADMINISTRATOR—Age 28 years; M.H.A. Degree, June, 1961; business office experience, large university hospital; completes residency, 200-bed mid-western hospital, June 1961.

COMPTROLLER—B.S. Degree; 3 years controller, 100-bed Ohio hospital; business office manager, large Pennsylvania hospital.

PERSONNEL DIRECTOR—Age 34 years; 7 years experience, 150-bed Michigan hospital; courses in accounting, University of Michigan.

DIRECTOR OF NURSING—M.A. Degree, 1958; 5 years experience. east or mid-west considered.

EXECUTIVE HOUSEKEEPER—4 years assistant housekeeper, large eastern teaching hospital.

PURCHASING AGENT—20 years experience.

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ANESTHETIST—Nurse; to join anesthesiologist and nurses. Write to MO 341, The MODERN HOSPITAL.

ANESTHETIST—Nurse; 95-bed general hospital, fully accredited, located in western Pennsylvania; good opportunity; salary open; many fringe benefits. Write to MO 342, The MODERN HOSPITAL.

ANESTHETIST—Nurse; for 604-bed general hospital, no pediatric department, 40 hour week, plus overtime, salary open, generous employee benefits. Apply Personnel Office, AKRON CITY HOSPITAL, 525 East Market Street, Akron 9, Ohio.

ANESTHETIST—Nurse; $500; new and modern surgery, unusually strong and well diversified surgical staff; good opportunity in new 260-bed expanding hospital; college town location; good personnel policies, 40 hour week, 7 holidays, hospitalization, social security. Apply F. J. O'Brien, Administrator, CHAMBERSBURG HOSPITAL, Chambersburg, Pennsylvania.

ANESTHETIST—Registered; salary open. Contact Administrator, ST. JOHN'S McNAMARA HOSPITAL, Rapid City, South Dakota. Phone FI 2-4911.

ANESTHETIST—Nurse; to complete staff of three for modern 100-bed hospital; winter ski and summer boating area in beautiful southern Vermont; start $5500 to $6000 dependent on qualifications; 4 weeks vacation, sick time, Blue Cross, etc. Write to Ronald H. Neal, M.D., Chief, Department of Anesthesiology, SPRINGFIELD HOSPITAL, Springfield, Vermont.

ANESTHETIST—Registered; male or female, fully accredited modern 150-bed hospital, department directed by chief of surgery; starting salary $600 plus 2 weeks vacation, health insurance, sick leave, social security and group life insurance, paid educational leave. Apply to Homer E. Allen, Administrator, CLINCH VALLEY CLINIC HOSPITAL, Richlands, Virginia.

ANESTHETISTS—Immediate openings in a chain of ten general hospitals located in the coal mining communities of eastern Kentucky, southwestern Virginia, and southern West Virginia; salary at the rate of $5,880 per annum, annual increments, 4 weeks paid vacation, 7 paid holidays, sick leave, non-contributory retirement plan plus social security. Write to MINERS MEMORIAL HOSPITAL ASSOCIATION, Box 61, Williamson, West Virginia.

DIETITIAN—Must have hospital experience and be qualified to take complete charge of this southern California hospital of 75-beds in the Pasadena area on a full-time basis; salary open. Reply R. M. Mershon, Personnel Director, P. O. Box 74, Temple City, California.

DIETITIAN—An opportunity for the qualified dietitian to make full use of her abilities in an interesting and rewarding position; ADA registration or comparable experience required; fully accredited, 250-bed, teaching, non-sectarian, community hospital; $2,000,000 development program underway, which will provide completely new dietary department, additional bed capacity, plus many other modern facilities. Apply Personnel Director, RAVENSWOOD HOSPITAL, 1931 W. Wilson, Chicago 40, Illinois.

DIETITIAN—Excellent opportunity for ADA registered dietitian planning modified diets, writing modified menus, selecting and training employees and directing work of dietary supervisors; 500-bed hospital with 180 dietary employees; salary commensurate with training and experience; liberal benefits. Reply Personnel Director, IOWA METHODIST HOSPITAL, Des Moines 14, Iowa.

(Continued on page 188)

classified advertising

POSITIONS OPEN

DIETITIAN—Or food service manager; for 90-bed general hospital; liberal vacation, hospitalization, sick allowances; salary open; Contact Emil Wieland, Administrator, JAMESTOWN HOSPITAL, Jamestown, North Dakota.

DIETITIAN—Chief; A.D.A.; with supervisory experience for 160-bed 27 bassinet general hospital fully approved by the JCAH and by the AMA for resident training; 40 hour week, salary open, 4 weeks vacation; social security; Blue Cross and Blue Shield available. Send resumé including experience, date available and salary desired to Miss G. A. Cooper, Director, WOMAN'S HOSPITAL, 1940 East 101st Street, Cleveland 6, Ohio.

DIRECTOR OF DIETETICS—Of Metropolitan Chicago General Hospital; excellent position for A.D.A. Member with extensive hospital food service experience; preference given those with a Master's Degree; some teaching background and presently employed as a director or assistant director of dietetics; will be responsible for entire operation of the food service department including: supervision of teaching program, staff dietitians, employees cafeteria and food production; supported by progressive administration and cooperative medical staff; top salary and benefits. Contact Richard W. Baum, Personnel Department, CHICAGO WESLEY MEMORIAL HOSPITAL, 250 East Superior Street, Chicago 11, Ill.

DIRECTOR OF NURSING—For a 180-bed hospital located in southern New England; must have Masters Degree and be capable of directing nursing school and service; salary $8,000 up, dependent upon experience; excellent fringe benefits; willing to consider persons with limited experience who have potential; please provide full details in first letter. Write to Box MO 338, The MODERN HOSPITAL.

DIRECTOR—Social service; female; in very active, fully approved, general hospital—247-bed capacity; currently expanding to 310-beds; located in the Hudson River Valley; pleasant working conditions, liberal personnel policies; state minimum salary requirement. Write to MO 340, The MODERN HOSPITAL.

DIRECTOR OF NURSING—Assistant; for modern 189-bed JCAH accredited hospital approximately 100 miles from New York City and Boston, Massachusetts; no school of nursing; major responsibility in-service program and orientation of new personnel; good personnel policies, salary open; bachelor's degree required, master's preferred, experience necessary. Please write Dirctor of Nursing, MOUNT SINAI HOSPITAL, Hartford, Connecticut.

DIRECTOR OF NURSING EDUCATION—New school and residence facilities in planning stage; small school, good salary, colleges, nice little city. ASBURY HOSPITAL, Salina, Kansas.

(Continued on page 190)

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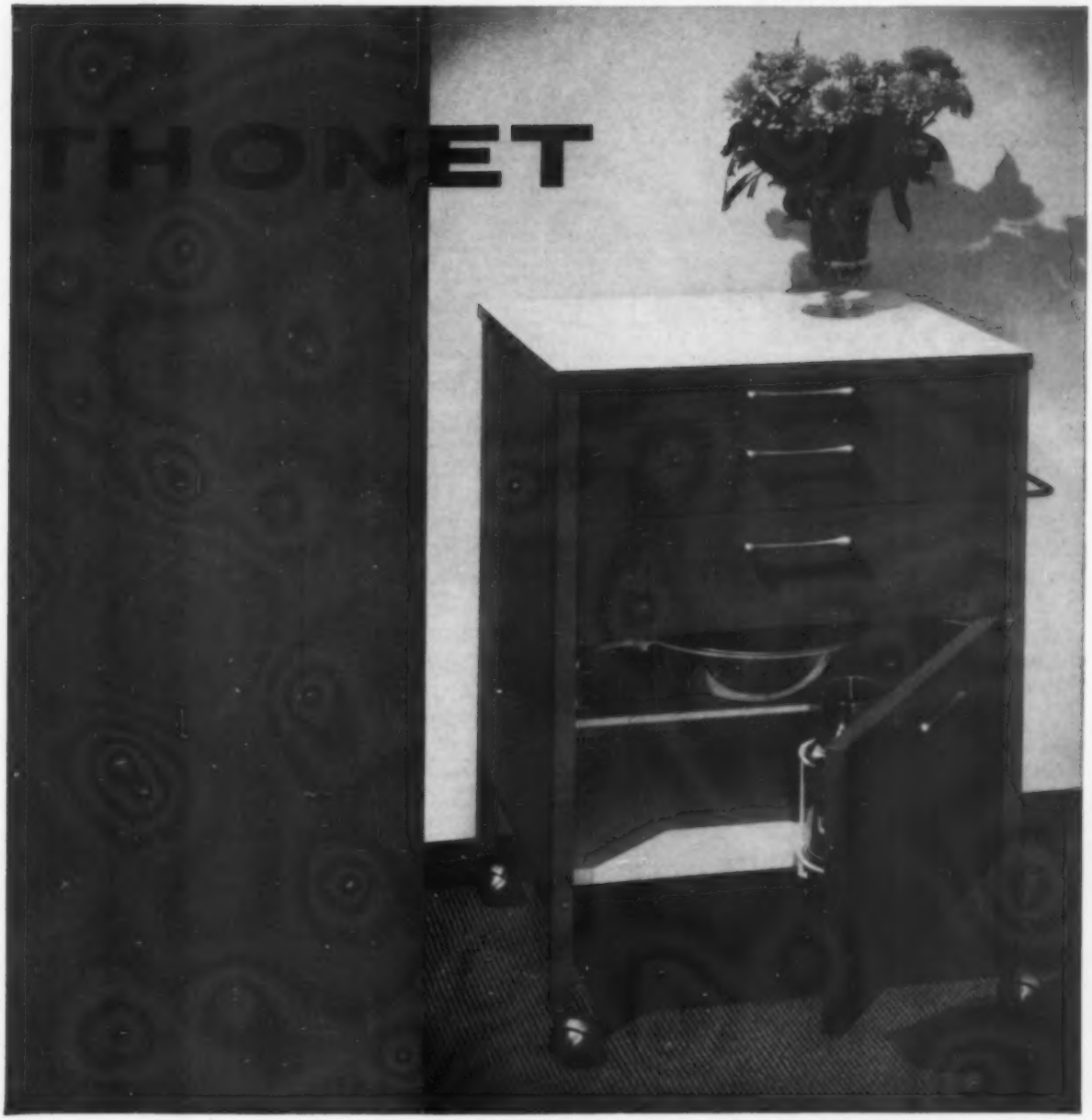

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SUPERVISOR OF NURSES—Position open for experienced supervisor of nurses; able to take full responsibility of all phases of nursing for a new 47-bed general hospital A-1 rating; salary open based on experience, education etc.; resort area near Yellowstone National Park, Wyoming. Apply Administrator, ST. JOHN'S HOSPITAL, P. O. 459, Jackson, Wyoming.

INSTRUCTORS—For medical-surgical nursing and instructor for pediatric nursing; NLN fully accredited diploma school, 150 students; college setting, attractive locality; numerous educational and recreational opportunities; CSNA employment standards; salary open; hospital pays percentage of Blue Cross coverage; liberal policies for off-campus professional activities. Apply to Director ST. VINCENT'S COLLEGE OF NURSING, 202 S. Lake Street, Los Angeles 57, California.

INSTRUCTOR—Fundamentals of nursing; B.S. degree and teaching experience required; includes both formal and clinical instruction; Diploma Program; remuneration and fringe benefits excellent. Apply The WILLIAM W. BACKUS HOSPITAL, Personnel Department, Norwich, Connecticut.

INSTRUCTORS—Medical surgical nursing; for hospital school of nursing; 324-bed JCAH accredited (when present construction is complete); hospital one block from main transportation line to city; apartments available close to hospital; liberal personnel policies; opportunity for study and time arranged. For further information write Director of Nursing, LUTHERAN MEDICAL CENTER, 4520 Fourth Avenue, Brooklyn 20, New York.

INSTRUCTOR—Medical & surgical; Degree in Nursing or Nursing Education, 150-bed hospital, modern; Central Pennsylvania; $4800 to start; send background information. CLEARFIELD HOSPITAL, Turnpike Avenue, Clearfield, Pennsylvania.

LIBRARIAN—Medical records; registered for expanded 116-bed hospital; opportunity to reorganize and operate department; original building only six years old, within one hour of New York City; liberal personnel policies; salary open. Write to MO 337, The MODERN HOSPITAL.

LIBRARIAN — Chief medical record; $450 to $550 per month; extensive vacation and other benefits; progressive and modern Wisconsin hospital. Write to MO 339, The MODERN HOSPITAL.

LIBRARIAN — Registered medical records; to head department in fully approved 247-bed general hospital; salary open. Send resume to Personnel Director, MOBILE GENERAL HOSPITAL, 850 St. Anthony Street, Mobile, Alabama.

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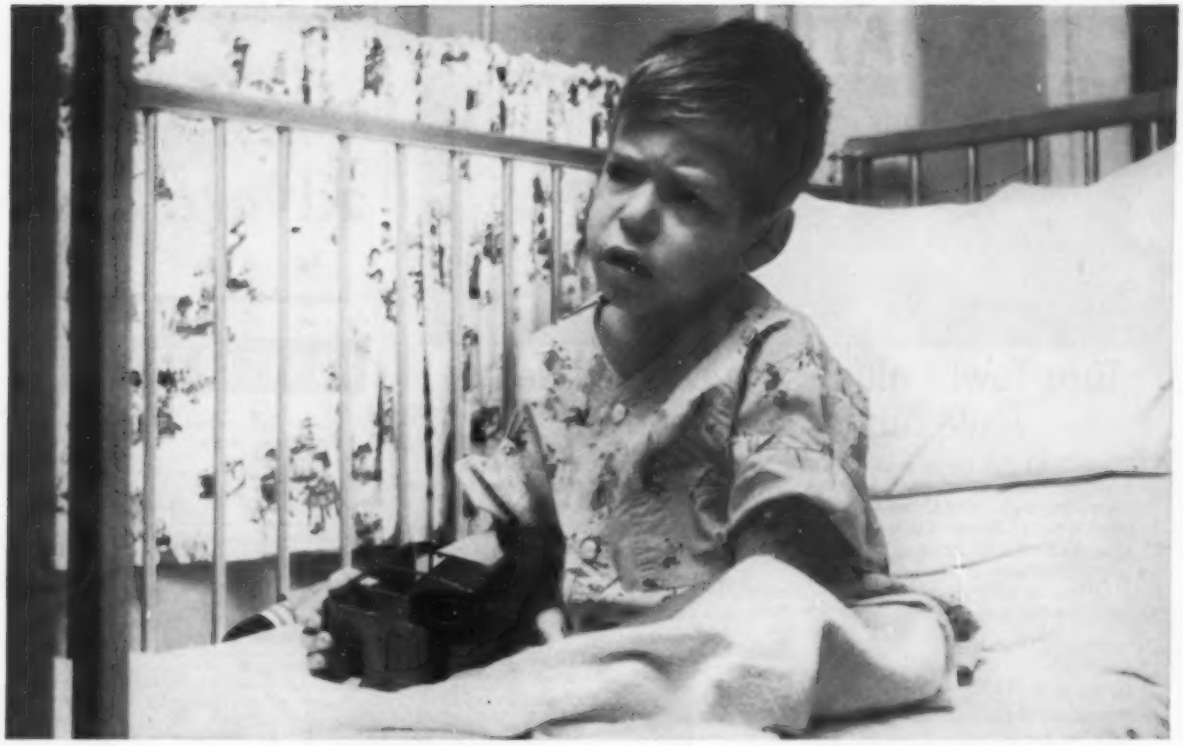
(Continued on page 192)



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Neil Kaplan is one of the many millions of Americans who might be dead or seriously incapacitated today were it not for the astounding fact that in the last two decades greater research progress has been made in the discovery and development of drugs than during the preceding two centuries. These new drugs, the great majority of which weren't available even ten years ago, have helped empty T.B. sanatoriums; helped lower the population of mental hospitals; effectively treated or prevented a host of killers, including—among many others—scarlet fever, pneumonia, venereal diseases, rheumatic fever, arthritis, certain heart disorders.

In 1960 alone, the American drug industry spent an estimated $214 million for research. Much of this effort was expended on research "gambles" that never came off; for in all research, failure is much more common than success. But the successes have had a tremendous impact on the nation's health.

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LIBRARIAN — Registered record; wanted immediately; modern, accredited community general hospital; 160-beds, presently expanding to 270-beds; 15 miles from Boston. Write Administrator, NORWOOD HOSPITAL, 792 Washington Street, Norwood, Massachusetts.

LIBRARIAN — Medical record; registered; with supervisory experience for 160-bed 27 bassinet general hospital fully approved by the JCAH and by the AMA for resident training; 40 hour week, salary open and commensurate with ability and experience. Send resumé including experience, data available and salary desired to Miss G. A. Cooper, Director, WOMAN'S HOSPITAL, 1940 East 101st Street, Cleveland 6, Ohio.

MANAGER — Credit collection; minimum 5 years hospital experience for 110-bed hospital. Apply Administrator, FORT PIERCE MEMORIAL HOSPITAL, Fort Pierce, Florida.

NURSES — General duty; for 320-bed JCAH accredited general hospital, only a few blocks from Lake Michigan beach and Lincoln Park; near Chicago Loop; school of nursing accredited by NLN; apartments available close to hospital; liberal personnel policies; openings on all shifts; must be eligible for Illinois registration. Write Director of Nursing, AUGUSTANA HOSPITAL, 411 W. Dickens Avenue, Chicago 14, Illinois.

NURSES — Registered; staff positions available for new 46-bed general hospital in San Francisco Bay area, opening October 1, 1961; beginning salary $340, differentials for obstetrics, operating room, etc.; fringe benefits include health insurance, vacation, paid holidays and sick leave. Write Administrator, VALLEY MEMORIAL HOSPITAL, P. O. Box 889, Livermore, California.

NURSES — Head; for emergency room, recovery room and intensive care unit; operating room nurses and charge nurses for 3-11 and 11-7 on medical, surgical, pediatric and obstetrical wards; must be eligible for registration in Colorado; presently 144-bed hospital with modern 80-bed unit, laboratory, operating rooms, X-ray and physio therapy opening in August; located in southern Colorado near mountain resorts; forty-hour week, liberal personnel policies, including social security. For information, write Director of Nurses, PARKVIEW EPISCOPAL HOSPITAL, Pueblo, Colorado.

NURSE — Registered; one: general and surgical duty; sixteen bed, privately owned hospital in college community. HENRY COOK POPE HOSPITAL, Richmond, Kentucky. Correspondence requested immediately, write or phone.

NURSES — General duty; R.N.; salary $3744 to $4680; good health, satisfactory ref-

(Continued on page 194)

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POSITIONS OPEN

erences prerequisites; excellent working conditions and benefits. Apply Personnel, PINELAND HOSPITAL AND TRAINING CENTER, Pownal, Maine.

NURSES — Registered and licensed practical nurses; positions open on all shifts; 3:00 P.M. to 11:00 P.M. mostly in need; 272-bed general hospital; new addition recently completed; entire hospital equipped with latest and modern facilities; centrally located in suburbs of Morris County, State of New Jersey, approximately 36 miles from New York City; nurses residence; private rooms nicely furnished; salaries and nurses' personnel policies equal or better than average throughout the state; if interested please write, giving full information and whether or not you are interested in receiving a set of policies; arrangements can be made for interview convenient to applicant. Write Personnel Director, DOVER GENERAL HOSPITAL, Jardine Street, Dover, New Jersey.

NURSES—General duty staff; 350-bed, modern, air-conditioned hospital; openings available in obstetrics, medical and surgical areas; 40 hour week with social security benefits, paid vacations, holidays, and sick leave; salary $329.00 per month plus shift differential. Write to Personnel Director, BETHESDA HOSPITAL, Cincinnati 6, Ohio.

NURSES — Registered; labor room; general staff duty; all shifts; 3-11 and 11-7 supervisor. Apply Director of Nurses, MARTINSVILLE GENERAL HOSPITAL, Martinsville, Virginia.

TECHNICIAN — Laboratory; in beautiful new expanding hospital located in progressive and interesting city, in smog free resort area; one hour drive from Los Angeles; beginning salary $500 per month, plus liberal fringe benefits. Write Administrator, ANTELOPE VALLEY HOSPITAL, Lancaster, California.

TECHNICIAN — Laboratory X-ray; female; experienced for new 47-bed general hospital; salary open; famous Jackson Hole area and Yellowstone National Park. Apply Administrator, ST. JOHN'S HOSPITAL, P. O. 459, Jackson, Wyoming.

PHYSIO-THERAPIST; Salary $487-$589; appointment may be made above entrance salary; graduation from an approved school of physical therapy; vacancy located in Reno, Nevada. Write to MO 343, The MODERN HOSPITAL.

ADMINISTRATIVE OPPORTUNITIES — (a) Administrator; 140-bed hospital, college town, midwest; $12,000. (b) Assistant administrator, charge maintenance, housekeeping, laundry, medical records, personnel; 600-

(Continued on page 196)

Quality-controlled throughout the world

Quality is 7-Up's first concern.

To keep this popular beverage uniformly pure and wholesome, a continuous system of quality control governs 7-Up production from start to finish.

All 7-Up ingredients, for example, must conform to rigid quality standards that are uniform throughout the world. From Bangkok to Boston. From London to Laredo.

Each 7-Up bottler constantly conducts exhaustive tests on sugar content, carbonation, water purification and bottle cleanliness, to name a few.

In St. Louis, the parent Seven-Up Company maintains its large, modern, central research and testing laboratories. Here, ingredient samples and "off the line" bottles of 7-Up are received from all 7-Up plants. These undergo every conceivable type of quality control investigation, careful records being kept on all samples tested.

This all-inclusive quality control accounts in large measure for 7-Up's unvarying flavor and purity. And these are the important attributes behind 7-Up's widespread acceptance—among hospitals, institutions and schools as well as the consuming public.

Wherever 7-Up is sold and enjoyed, uniform purity and wholesome refreshment go with every sip

Nothing does it like Seven-Up!

For additional information, use postcard facing back cover.

classified advertising

POSITIONS OPEN

MEDICAL BUREAU—*Continued*

bed hospital, south; $8-$10,000. (c) Assistant administrator; charge all accounting operations, large eastern hospital; $9,000. MH 5-1

ANESTHETISTS — (a) Anesthetist; small Alaska mountain resort hospital near U. S. Naval Base; $7200, plus. (b) Anesthetist; male or female; responsible entire service 100-bed hospital near Chicago; $9,000. MH 5-2

DIETITIANS — (a) Chief; 400-bed hospital, Houston; $7500. (b) Organize brand new department 200-bed hospital, Colorado; exceptional opportunity. MH 5-3

DIRECTORS OF NURSES — (a) Direct nurses, also manage small Hawaiian hospital; $8-$10,000. (b) Male director, nurses; 375-bed general hospital; excellent opportunity for ambitious man; south industrial center. (c) Director, nursing service & school; 350-bed hospital, commuting distance New York City; $10,000 start. (d) Direct nursing service 120-bed hospital, Illinois; also act as assistant administrator; top salary. MH 5-4

EXECUTIVE HOUSEKEEPERS — (a) Male or female; top flight experience, 480-bed hospital near Dallas; $7200. (b) Direct department of 100 in 300-bed hospital near New York City; $7200. MH 5-5

MEDICAL RECORD LIBRARIANS — (a) Head department of 16; 250-bed hospital, medical affiliation; commute New York City; $7-$8000. (b) Chief; 250-bed hospital, Florida seacoast resort; $6500 up. (c) Medical record technician; excellent opportunity for professional growth; $400 start for one year experience; or will consider R.R.L; $550; midwest; 200-bed hospital MH 5-6

ADMINISTRATORS—(a) Director of institutions; county post; $22,000; midwest. (b) Direct 175-bed JCAH; $15-$17,000; near Boston. (d) Administer, 175-bed general; $18,000; near Cleveland (e) Direct 110-bed JCAH; $10-$15,000; south. (f) Assistant Director large general; $18-$20,000; west coast. (g) Assistant director; 700-bed $12-$14,000; midwest. (h) Assistant director, experienced in accounting; to $12,000; south Atlantic.

EXECUTIVE POSTS—(j) Clinic manager; experienced; to $15,000; south. (k) Comptroller; prefer CPA; 350-bed teaching hospital to $11,000; midwest. (I) Personnel director; large group and hospital; requires hospital experience; mideast. (m) Purchasing director 800-bed hospital; to $10,000; midwest.

CHIEF PHARMACIST—190-bed Ohio hospital.

BUSINESS MANAGER—(a) 110-bed hospital, southeast. (b) 200-bed Michigan hospital. (c) Credit-collection manager, 200-bed hospital, near Baltimore. (d) Small Ohio hospital; building program.

ADMINISTRATIVE ASSISTANT—(a) 100-bed hospital, central states. (b) 250-bed hospital, west; purchasing experience. (c) 225-bed hospital, Massachusetts; to $10,000 per annum. (d) Sisters' hospital, 175-beds; south.

ADMINISTRATOR—Anesthetist; small hospitals, west, southwest.

ADMINISTRATOR—(a) 75-bed hospital, northeast. (b) 60-bed Ohio hospital. (c) 100-bed hospital, near Pittsburgh. (d) 35-bed Ohio hospital.

DIRECTOR, NURSING SERVICE—(a) 110-bed Ohio hospital. (b) 190-bed Michigan hospital. (c) Assistants; to $7,500.

DIRECTOR, School of Nursing—200-bed mid-western hospital.

EXECUTIVE HOUSEKEEPER—(a) 400-bed hospital, New York. (b) 175-bed mid-western hospital.

(Continued on page 198)

PURAPHEN®

Accepted for Hospital Use

The Most Effective Cleaner-Germicide You Can Use

WHY IS PURAPHEN A SUPERIOR CLEANER?

PURAPHEN is a *built* detergent; a high sudser with a pleasant odor. Its *balanced blend* gives PURAPHEN maximum cleaning efficiency, greatest economy. For example, PURAPHEN removes dirt, grime, dull soap film and old wax from the invisible pores as well as from the surface of any floor. And through emulsification and suspension keeps the dirt from settling back on the floor. Dirt is rinsed away freely, yet PURAPHEN leaves no sticky deposit or dulling film. *Approved by Underwriters Laboratories for use on conductive floors.*

Proved Performance

- ✔ Effective Against Escherichia coli (urinary tract infections)
- ✔ Effective Against Salmonellacholeraesuis (food-poisoning outbreaks)
- ✔ Effective Against Virulent Tubercle Bacilli (Tuberculosis infection)
- ✔ As a Fungicide, Effective Against Trichophyton interdigitale ("Athlete's Foot")
- ✔ Microsporum gypseum ("Ring Worm" of skin and scalp)
- ✔ Epidermophyton floccosum ("Athlete's Foot")
- ✔ Candida albican's (foot, mouth and vaginal infections)
- ✔ Effective as a Bacterial Sporicide against spores of Bacillus subtilus and Clostridum tetani (tetanus bacillus)
- ✔ Effective Against Pyogenic and Enteric Bacteria
- ✔ Effective Against Salmonella typhosa (typhoid bacillus)
- ✔ Effective Against Staphylococcus aureus (staph infections—abscesses, boils, pimples)
- ✔ Effective Against Streptococcus fecalis ("strep" infections)
- ✔ Effective Against Pseudomonas aeruginosa (Bacillus of green pus)
- ✔ Effective Against Proteus vulgaris (Ear and chronic infections)

LIQUID SURGICAL SOAP

ANASEP — 40% Solids, contains Hexachlorophene. A delicately adjusted formula containing the finest vegetable oils. Low pH. Superfatted to leave skin soft. Reduces skin bacteria 97% in 5 days. Pleasantly scented-green in color.

ASEPTEX — 40% Solids, contains Hexachlorophene. A balanced formula containing Lanolin and other skin emollients. Low pH. Reduces resident skin bacteria 97% in 5 days. Pleasantly scented-red in color.

ASEPTROL — 20% Solids, contains Hexachlorophene. Same as Aseptex except diluted for dispenser use.

U. S. P. TINCTURE of GREEN SOAP. High quality vegetable oil soap combined with specially denatured alcohol. Conforms to U.S.P. specifications. Used for treatment of skin disease and also for shampoo.

PED-O-FLO

Foot Operated Liquid Soap Dispensers

Model 303
1 Quart plastic ..... soap jar

Model 202 .....
1 quart glass soap jar

Model 101
1 pint glass ..... soap jar.

Office Master .....
1 pint disposable cartridges.

Conforms with the most rigid requirements of surgical asepsis

HOSPITAL DISPENSER STAND

All Chrome — Low Cost Portable Surgical Soap Dispenser

Attractive stand has heavy non-tip non-slip base. Three hard rubber cleats attached to base insures a steady wobble-free performance.

Weighing less than 8 pounds it can be easily lifted and moved with one hand by a nurse.

The heavy chrome plating produces an attractive appearance and is especially easy to clean . . . also there is no danger of rusting.

This low cost stand has been designed for use with Ped-O-Flo dispensers-

PECK'S PRODUCTS CO.
610 E. CLARENCE • ST. LOUIS 15, MISSOURI

Gentlemen:
☐ Send prices and information on _____
☐ Have representative call.

NAME _____

FIRM _____

STREET _____

CITY _____ ZONE _____ STATE _____

For additional information, use postcard facing back cover.

classified advertising

PLACEMENT BUREAUS

MISCELLANEOUS

(Continued on page 200)

Pittsburgh's Children's Hospital gets

Complete Hospital Sanitation with Natco Vitritile

Few of the young patients at Children's Hospital in Pittsburgh, Pennsylvania know what the word "sanitation" means—much less what it means to their own general health. But the hospital's management is aware of its importance. That's why Natco Vitritile was selected for all areas where sanitation is a "must"... food processing areas, hallways, laboratories ... just to name a few.

Vitritile is a ceramic glazed structural clay facing tile that is non-porous and *easily maintained*. As a matter of fact, an occasional cleansing with common soap and water or detergent is all that's necessary to *keep* Vitritile spotlessly clean and sanitary.

To assure yourself – and your patients – of *complete* sanitation consider Natco Vitritile in your remodeling or new building plans.

Natco Vitritile is a completely fireproof, load bearing, genuine fire clay building material. It comes in three nominal face sizes: 8" x 16", 5⅓" x 12" and 5⅓" x 8".

NATCO CORPORATION

General Offices: 327 Fifth Ave., Pittsburgh 22, Pa. **Other Branch Sales Offices:** Boston, Chicago, Detroit, Houston, New York, Philadelphia, Pittsburgh, Syracuse, Birmingham, Ala., Brazil, Ind. **In Canada:** Natco Clay Products Ltd., 57 Bloor St., W., Toronto

classified advertising

FOR SALE

MEMORIAL HOSPITAL, Belleville, Illinois, has the following surplus equipment, all in excellent condition, for sale:

1—Bishop Starch Cooker, Model B3-5 Serial #L1757

1—Bishop Soap Cooking Tank, Model B6 Serial #L1922

1—G. H. Bishop Co. Ironing Board

1—Wilmot-Castle Instrument Sterilizer Type #150, Serial #372576

1—Southern Cross Nipple Washer Model #NW-604

3—American Std. Water Closet NEOLO #HF 13470 VN (Integral Seat)

1—Hobart Potato Peeler, Model #S-12, Serial #3736, 5 lb. capacity

1—Castle Flask Heating Cabinet Model #3000, Serial #381103, 77" high x 29" wide x 29" deep 60 lb. steam — free standing type

FOR SALE

IDEAL FOOD CONVEYOR CART, Model #5020 T (hold 16 trays) In good condition. Price to be quoted upon inquiry. Write to BLESSING HOSPITAL, 1005 Broadway, Quincy, Illinois.

SCHOOLS—SPECIAL INSTRUCTION

The CHICAGO LYING-IN HOSPITAL AND DISPENSARY of the University of Chicago offers a six-months course in obstetric nursing to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 5841 Maryland Avenue, Chicago 37, Illinois.

ST. FRANCIS HOSPITAL School of Anesthesia offers to graduates of accredited schools of nursing, an 18 months course in anesthesia. AANA accredited; approved under G.I. Bill of Rights. Stipends offered throughout course. Classes begin April 1 and October 1, each year. Write Sister M. Catherine Ann, O.S.F., C.R.N.A., Director, School of Anesthesia, ST. FRANCIS HOSPITAL, Peoria 4, Ill.

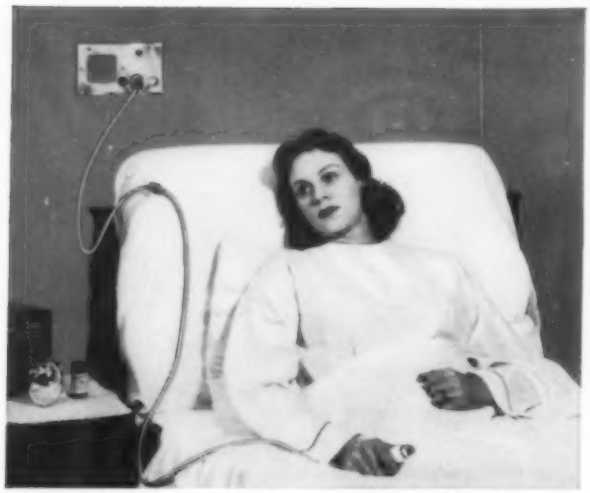
UNIVERSITY OF MICHIGAN offers an 18 month course for nurses interested in anesthesia. Accredited by the American Association of Nurses Anesthetists. Unlimited opportunities for endotracheal intubations, open chest, and neuro surgery anesthesia. Stipend provided. For information write "School for Nurse Anesthetists, UNIVERSITY MEDICAL CENTER, Ann Arbor, Michigan."

MT. CARMEL MERCY HOSPITAL offers and 18 month course in Anesthesiology to registered nurses of accredited schools of nursing. Approved by American Association of Nurse Anesthetists. Stipend provided. Write for complete details regarding theoretical and clinical teaching and requirements for entrance. School of Anesthesia, MT. CARMEL MERCY HOSPITAL, Detroit 35, Michigan.

CHARLES T. MILLER HOSPITAL offers qualified graduate nurses a 16 weeks' course in operating room nursing. The course includes instruction and supervised experience in all surgical specialties as well as teaching and management techniques. Room, board, laundry, and a stipend of $125 per month are provided. For information address Director of Nursing, CHARLES T. MILLER HOSPITAL, St. Paul 2, Minn.

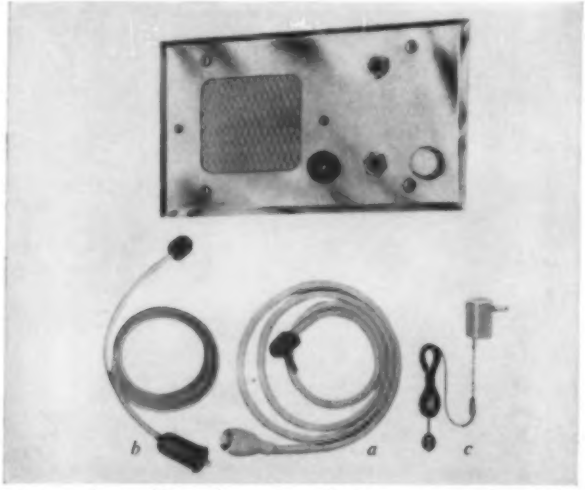
BARNES HOSPITAL—Offers an 18 month post-graduate course on Anesthesia to registered graduate nurses. Theoretical requirements of the American Association of Nurse Anesthetists met, Miss Helen Vos, R.N., B.S., Educational Director, Clinical training includes all techniques and procedures. Stipend provided. For information, write Mrs. Dean Hayden, Director, School of Anesthesia, BARNES HOSPITAL, St. Louis 10, Mo.

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $75.00 a month is provided. For full information, apply to the Director of Nurses, PROVIDENCE LYING-IN HOSPITAL, Providence 8, Rhode Island.



▲ *The patient may talk to the nurse—even whisper—from any position in her bed.*

▲ *The nurse may talk to patients from her station, monitor their rooms, cancel their signals.*



▲ *Interchangeable cord sets for calls from: a. normal patients; b. patients who cannot speak or hear; c. oxygen-tent patients.*

▲ *Remote reply units enable the nurse to accept calls and talk to patients from locations away from her station.*

AUTH NURSES' CALLING SYSTEMS

Can Tremendously Benefit Your Hospital

Statistics show that a modern nurses' calling system, properly installed and properly used in your hospital, will greatly increase the nurses' effectiveness through saved footsteps, ability to take care of more patients, greater concentration on direct bedside care, and increased morale and feeling of accomplishment. This offers the tremendous benefits to the hospital of greater staff efficiency and service, reduced operating costs, more and speedier recoveries, and increased goodwill.

To obtain these benefits you will want not *any* nurses' calling system but the best—Auth. And Auth is best because it reflects over forty years of experience in this field; because it is deliberately simplified to make it easy to understand and use; because its design minimizes installation costs.

You can specify Auth nurses' calling systems for your hospital with confidence—and Auth doctors' in-and-out register and paging systems. A representative is ready to discuss them with you. Please call upon us. No obligation.

Auth Electric Company, Inc.
LONG ISLAND CITY 1, NEW YORK

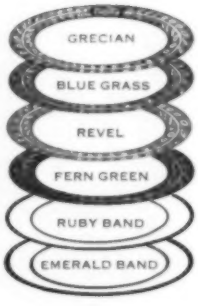
SPECIALISTS IN HOSPITAL SIGNALING AND COMMUNICATION SYSTEMS, CLOCK AND FIRE ALARM SYSTEMS

For additional information, use postcard facing back cover.

THIS IS WHERE DECOR KEEPS ITS PROMISE

More DECOR plates get past this breakage point than any other make. That's why DECOR makes your budget look better. It is designed expressly for mass feeding. It has no glaze to wear off. Its hard and nonporous structure won't crack. It's less likely to chip or stain. Check your breakage costs against this chart and then call your DECOR dealer. Or write to Department HO-41, Corning, N. Y.

CORNING *Décor* DINNERWARE



WHAT'S NEW

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form on page 251. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Cafeteria Display Case For Frozen Desserts

Designed especially for use in cafeterias, the new Bally Cafeteria Ice Cream

Merchandiser permits display of ice cream and other frozen desserts so that they can be picked up without having to be served. Even sundaes and plates of ice cream can be made up in advance and still retain their appetizing appearance for hours when displayed in the new case. Known as Model CAFI-36, it is completely clad in stainless steel inside and out and is designed to fit into both existing and new cafeteria line-ups. A storage compartment in the base holds reserve stock near the rugged but quiet-operating Copeland condensing unit. Model CAFM-36 is a matching companion case for the display of milk. **Bally Case & Cooler, Inc., Dept. NR-7, Bally, Pa.**

For more details circle #170 on mailing card.

Sterile Suture Packaging Delivers Packets Dry

Sterile Pack–Dry is the name given to a new sterile suture packaging system introduced by Ethicon. The system delivers suture packets dry in a foil-plastic overwrap and is an addition to the Ethicon Sterile Pack introduced in 1950 to supply suture packets in a sterilizing solution.

Both systems are compatible with suture handling and unused suture packets removed from the overwrap may be placed in sterilizing solution, or they may be returned to Ethicon for resterilizing and repackaging. The operating room nurse just tears open Sterile Pack–Dry to expose the suture. No instruments are necessary for opening the packet or removing the suture. A complete line of Ethicon sutures is available in the new dry packaging, including standard tubes, Sutupak(R) precut sterile lengths and Atraloc(R) needle suture combination. **Ethicon Inc., Somerville, N. J.**

For more details circle #171 on mailing card.

Storage and Dispensing Cabinets Are Practical and Attractive

Beauty of design and construction, with practical features for time-saving and efficiency in use, are built by E. H. Sheldon and Company into a new line of Storage and Dispensing Cabinets specified by McKesson & Robbins as a result of a study of pharmacy layout and design. The compact wall storage cabinets, with shallow depth design and adjustable shelves inside and on the doors, put all supplies in immediate view of the pharmacist when the cabinet is open. The dispensing section for prepackaged pharmaceuticals has sloping fiberglass shelves

which move a new package into place as the front one is removed, and tell at a glance when supplies are low. Movable partitions permit wide flexibility in accommodating packages of varying sizes and shapes. Other features include rugged steel construction; institutional type hardware; permanent finishes in five pastel colors; a new compounding table, and other advantages. Assembling the units necessary to create the best layout and equipment for the need is done with the assistance of McKesson's trained staff of Design Consultants. **McKesson & Robbins, Inc., 155 E. 44th St., New York 17.**

For more details circle #172 on mailing card.

Sterile Abdominal Pad in Curity S-E Pack

The new nine by five-inch Wet-Pruf Abdominal Pad in the Curity S-E Pack assures sterile delivery of the pad from the wrapper. It is pre-packed and presterilized, ready for instant use. Preparation and sterilizing time and handling are saved and the narrow rectangular dressing is designed to fit the wound and save on dressing material. **Bauer & Black Div., 309 W. Jackson Blvd., Chicago 6.**

For more details circle #173 on mailing card.

Electra II Food Cart Matches Hot and Cold

Side-by-side heated compartment trays match horizontally with the corresponding patient tray in the cold compartment,

speeding service from and loading of the new Electra II Food Cart. The "Tray-on-Tray" concept of loading and serving permits placing the hot food tray on the cold food tray without delay or confusion, and the smaller hot food tray matches the larger tray snugly. Loading from conveyor belts is fast enough to keep up with conveyor speeds, thus saving time, and with the "Tray-on-Tray" system the possibility of error in coordinating trays is eliminated. Other features of the Electra II include more usable top space, an ice cream freezer, utility shelf and drawer, and a space-saving compressor recessed within the unit. The Electra II mobile food service cart was introduced only after considerable research and actual hospital use. **Meals-on-Wheels-Crimsco, Inc., 5001 E. 59th St., Kansas City 30, Mo.**

For more details circle #174 on mailing card.

High Back Lounge Chair for Patient Comfort

Especially comfortable for convalescents, the No. 703 high back lounge chair features loose cushions and an attractive

slat back high enough to support the head. The firm seat makes it easy for a patient to get up by leaning on the arm rests, yet the upholstered cushions are soft and comfortable. Available in a wide range of covers and finishes, the chair is adaptable for lobbies or waiting rooms. **American Chair Co., Sheboygan, Wis.**

For more details circle #175 on mailing card.

(Continued on page 204)

Improved Medicine Station Features Individual Trays

The improved Medi-Prep Medicine Station, Model No. MP–248, features removable plastic trays on each shelf to facilitate the storing and dispensing of each patient's medicines. Card holders for each tray ensure positive patient identification. The unit is avaliable with or without shatterproof glass doors. **Market Forge Co., Everett 49, Mass.**

For more details circle #176 on mailing card.

Surgilope SP Dispensing Rack For Safe, Efficient Handling

Developed as another aid to safe, efficient suture dispensing in the operating room, the new dispensing rack for Surgilope SP sutures is attractive and functional. It is molded of clear plastic for complete visibility of the product, and is divided into six sections, each of which will hold more than three dozen suture envelopes. The racks are designed with a slight backward slant to assure stability of the rack and its contents, and two or more racks may be placed together where additional supplies are required. **American Cyanamid Co., Surgical Products Div., 1 Casper St., Danbury, Conn.**

For more details circle #177 on mailing card.

Bedside Litter Basket Clips to Frame

Autoclavable plastic forms the new "bed and cart basket" which clips to either bed frames or wheelchairs in seconds, and is as easily removed for emptying and cleaning. It can also be used for

storage on beds, wheelchairs, carts or counters. Two clips are provided for mounting on either tubular or flat steel frames and the noiseless, dent and rustproof basket is offered in gray or beige. **Rubbermaid Incorporated, 1205 E. Bowman, Wooster, Ohio.**

For more details circle #178 on mailing card.

Tornado 280 Floor Machine Has Smooth One-Hand Operation

Featuring perfect balance due to weight and movement over the exact center of the machine, the new Tornado 280 floor machine provides completely smooth, one-hand operation with no vibration or bucking. The 280 operates at a continuous 25 per cent overload without danger of overheating, has low operating amperage per horsepower, non-loosening handle height adjustment, recessed switch levers and heavy three-wire safety cable with third wire grounding. Machines are available in 15, 17, 19 and 22-inch brush sizes. **Breuer Electric Mfg. Co., 5100 N. Ravenswood Ave., Chicago 40.**

For more details circle #179 on mailing card.

Cafeteria Display Unit Has Plate Glass Guards

Curved plate glass protector guards and curved aluminum support brackets improve and speed service with the Bastian-Blessing Custom-Modular line of cafeteria equipment. The post obstruction on the serving side is eliminated and the glass unit is more sanitary. **Bastian-Blessing Co., 4203 W. Peterson Ave., Chicago 46, Ill.**

For more details circle #180 on mailing card.

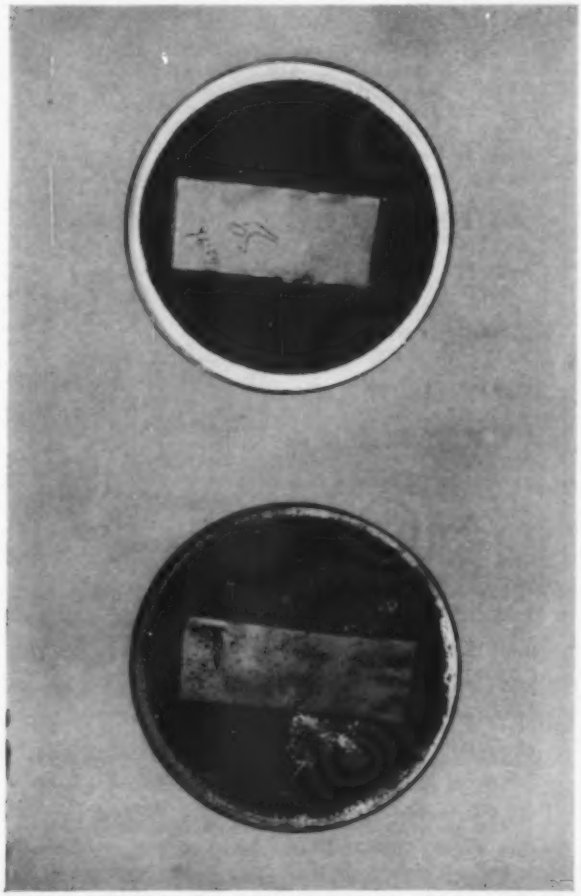
(Continued on page 206)

Which is your most sanitary window treatment?

Flexalum Twi-Nighter blinds are the most sanitary, and easiest-to-keep-sanitary window covering. Flexalum plastic tapes deter bacteria because there are no loose fibers or porous surfaces to absorb dirt as there are in fabric tapes. (See test below.) And Flexalum wipe-clean tapes won't fray, fade, stretch or shrink. Twi-Nighter blinds are made with a special nylon cord that has a harder, smoother, more sanitary surface than cotton cord. Flexalum's spring-tempered aluminum slats have a baked finish of enamel and emulsified wax that makes them exceptionally smooth and soil resistant. They won't rust, chip, crack or peel. You have the protection of a written five year guarantee by Bridgeport Brass Company.

Flexalum®

What's more, with Flexalum Twi-Nighters you can give your patients maximum range of light control — from soft diffused daylight to complete darkness. Write us today for free literature, or name of your nearest Flexalum dealer. He'll be glad to give you cost estimates at no obligation. Bridgeport Brass Company, Hunter Douglas Division, 30 Grand Street, Bridgeport 2, Connecticut.



In Bacteria Test (directly above) fabric tape picked up over 700,000 bacteria per square inch. Flexalum wipe-clean plastic tape (top) picked up only 100 bacteria per square inch.* *Gar-Baker laboratory test.

Easy-to-clean Flexalum Twi-Nighter blinds give complete light control, let patients rest during even the brightest, sunniest days because they close tighter than ordinary blinds.

Molded Plywood Chairs Stack in Minimum Space

Two styles of molded plywood seat and back chairs are offered by Howell.

Both stack in minimum space and are attractive and comfortable. Chair No. 223 of walnut woodgrain has a comfortably contoured back and roll front seat with Satin chrome or Bronzite finish on the square tubular frame. The No. 219 companion chair has foam-filled seat and back with basic model plywood frame. Upholstery in Naugahyde over foam has a protective welt around the edges. Both chairs have wall-saver legs. **The Howell Co., Div. of Acme Steel, St. Charles, Ill.**

For more details circle #181 on mailing card.

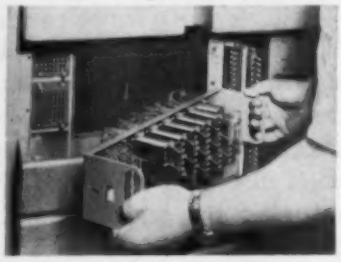
Anti-Slip Factor in Simoniz Floor Finish

Designed for extra safe floor care, Super Anti-Slip Floor Finish developed by Simoniz incorporates its "Ladium Formula." The anti-slip factor does not affect the full luster, hardness and durability of the finish which is suitable for all resilient and hard floors. **Simoniz Co., 2100 Indiana Ave., Chicago 16.**

For more details circle #182 on mailing card.

Telematic Internal Switchboard Expands to Meet Needs

Developed to provide automatic internal communications, the Telematic switchboard can be expanded on the user's premises without soldering irons or special skills. By means of plug-in relay sets and plug-in connecting cables, it can be assembled to provide any number of



stations up to 240 and as many as 32 links. The number of stations in any installation can be increased by 20 to 25 per cent by adding selective ring common talk stations. The system comprises a basic 60 line-8 link switchboard and power supply, extension frames and group selector frames. It is a self-contained unit, completely wired and equipped with necessary relays to provide a wide range of features. **Dictograph Products Inc., Danbury, Conn.**

For more details circle #183 on mailing card.

Wireless Dictation and Recording Offered with Remote-Tape

Remote wireless dictation and recording, allowing users to range a wide distance from the actual recording machine

while carrying only a compact, pocket sized unit which contains both microphone and transmitter, is introduced in Remote-Tape. Every message dictated into the miniature dictating unit is automatically recorded by a standard Geloso Stenotype machine which can be located as much as a half mile away. The complete Remote-Tape unit consists of a wireless microphone, a receiver-control unit, an actuator which starts and stops the recording unit, and the standard Geloso Stenotape recording/transcribing unit. Due to an important design feature, the recording unit operates only when messages are actually being dictated, leaving no blank spaces on the tape, and a gating circuit makes it impossible for any other transmitter to activate the recording machine. **American Geloso Electronics, Inc., 251 Park Ave., New York 17.**

For more details circle #184 on mailing card.

(Continued on page 208)

Low-Priced Copymaker in Lightweight Century

The Apeco "Century" is a lightweight, versatile copymaker which copies any document, regardless of original color, up to 8½ inches wide, in any length. Other

features include an exposure control dial with the exclusive Apeco color band, nylon gears that never need lubricating, and an impact-proof plastic housing. The new machine is low in price, efficient and virtually trouble-free in operation. **American Photocopy Equipment Co., 2100 W. Dempster St., Evanston, Ill.**

For more details circle #185 on mailing card.

Sorbette "Twin-C" Towel Folded to Open Full Size

As the special Sorbette "Twin-C" towel is pulled from the dispenser, the new folding arrangement makes it unfold auto-

matically to full size. The user grips only one thickness of the high quality Sorbette toweling which offers exceptional moisture capacity, discouraging the use of more than one towel. **Crown Zellerbach Corp., One Bush St., San Francisco 4, Calif.**

For more details circle #186 on mailing card.

Architectural Steel Canopies Provide Weather Protection

Effective weather protection as well as enhanced appearance are provided with the new line of architecturally designed steel canopies introduced by Armco. The canopies are available in a wide choice

of styles and sizes, delivered ready for erection. They provide a weathertight roof of interlocking Armco Steelox panels, flat and smooth underneath and coated with aluminum or zinc to reflect the sun's rays and resist corrosion. **Armco Drainage & Metal Products, Inc., Middletown, Ohio.**

For more details circle #187 on mailing card.

(Continued on page 210)

Comptroller Maurice L. Cook

With Burroughs Accounting Equipment, collections improve more than 70%

The scene: Children's Mercy Hospital, Kansas City, Missouri. **The jobs:** patient accounting, accounts receivable, accounts payable, general ledger, payroll and all statistical applications. **The equipment:** one Burroughs F 1500 Alphanumeric Accounting Machine. **The results:** in the words of Comptroller Maurice L. Cook: "Splendid—throughout our accounting operation. Before we installed our Burroughs machine, patient billing was anywhere up to a month and a half behind. Now because of this equipment's many automatic features, all expense records are updated daily, total bills presented at the time of discharge. As a result, collections have improved more than 70% over the past year. The machine also helps immeasurably in preparing accurate, detailed records for county reimbursement."

Burroughs—TM

Join the many successful hospitals helped to new accounting efficiency by Burroughs Corporation. Whatever your problem, our representatives offer you the experience and capabilities in systems analysis to solve it. And we have the equipment, from adding machines to electronic computer systems, to make the solution work. Call our nearby branch now. Or write Burroughs Corporation, Detroit 32, Michigan.

Burroughs Corporation

"NEW DIMENSIONS / in electronics and data processing systems"

Diuretic Service Kit Performs Special Function

Designed to aid the hospital pharmacist in providing physicians with accurate and complete information on indications, dosage and limitations for two potent diuretics, Metahydrin and Mercuhydrin, the new Lakeside Diuretic Service Kit contains official product brochures, package inserts, index cards, copies of the diuretic monograph, "Of Water, Salt and Life," and samples of the two diuretics. **Lakeside Laboratories, Inc., 1707 E. North Ave., Milwaukee 2, Wis.**

For more details circle #188 on mailing card.

Zen Liquid Cleaner in Polyethylene Bottle

Zen liquid vitreous cleaner is now supplied in a hand-fitting, lightweight, unbreakable polyethylene bottle. Special fluting prevents slipping, even when hands are wet. A special poly "Pour-A-Cap" also provides greater economy in use of the one-step cleaner which cleans, sanitizes and deodorizes in one application. **J. I. Holcomb, Indianapolis, Ind.**

For more details circle #189 on mailing card.

WhirlPower Burner-Boiler for Moderate-Sized Institutions

A burner-boiler package that provides steam or hot water requirements with one burner and one boiler precision-locked in combination and ready for instant installation is provided in the new Iron Fireman WhirlPower. It can be fueled either by gas or oil or gas-oil as desired and is introduced for use in medium-sized institutions. **Iron Fireman Mfg. Co., 3170 W. 106th St., Cleveland 11, Ohio.**

For more details circle #190 on mailing card.

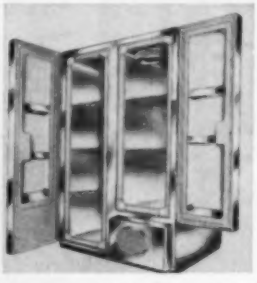
Sunroc Water Coolers Eliminate Pre-Cooler

A redesigned refrigeration system which, without any accessories or adjuncts, produces the entire capacity stated, is featured in the new line of Sunroc water coolers. The pre-cooler is eliminiated, ensuring full capacity of cooled water. The coolers are available in a variety of sizes and styles, including floor types, wall-hung models and remote installations. **Sunroc, Div. P-C, Glen Riddle, Pa.**

For more details circle #191 on mailing card.

Silco Refrigerator Line Features Door Shelves

A complete new line of Silco refrigerators and freezers for institutional use is introduced by Silver Refrigeration. Two special features are the space-saving door shelves and a streamlined blower coil which also saves space. Up to 30 per cent increase in storage space without added overall dimensions is provided with the door shelves in both refrigerators and up-

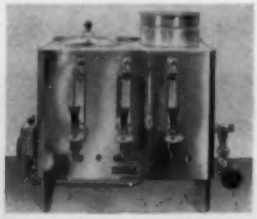


right freezer models. The new blower coil features the Silco circular design for maximum air circulation efficiency in a mere 3½-inch height. Slides and shelves are interchangeable without the use of tools, and may be used separately or in combination. **Silver Refrigeration Mfg. Corp., 1469 Utica Ave., Brooklyn 34, N.Y.**

For more details circle #192 on mailing card.

(Continued on page 212)

Twin One Gallon Urn Is Compact Coffeemaker



The "Twin One Compact" Coffeemaker requires only 4.1 cubic feet of space without brewing baskets, or five cubic feet with them. Available in gas, electric or steam models, the urn is a pour-over type that permits brewing fresh coffee frequently, and is inexpensively and easily serviced. **The Continental Coffee Co., 2550 N. Clybourn, Chicago 14.**

For more details circle #193 on mailing card.

Hospital Dispenser Stand Is Made of Chrome

Weighing less than eight pounds, the new low-priced, all chrome Hospital Dispenser stand is equipped with three hard rubber cleats at the base to ensure steadiness. It is designed for use with various models of Ped-O-Flo Liquid Soap Dispensers and can be used as either a single or double unit. The heavy chrome plating is easy to clean, prevents rust and is attractive in appearance. **Peck's Products Co., 610 E. Clarence, St. Louis 15, Mo.**

For more details circle #194 on mailing card.

Sonotone "Securitone" Soothes Infants in Nursery

Developed by Dr. Lee Salk, consultant research psychologist, the Sonotone "Securitone" reproduces the sound of a normal heartbeat. Contained in a plastic case the size of a small table radio, the "Securitone" is designed for use in a bassinet or crib to simulate the sound of the mother's heartbeat. Tests indicate that

newborn infants exposed to the sound of the mother's normal heartbeat gained weight, slept better and cried less than infants not so exposed. **Sonotone Corp., Saw Mill River Rd., Elmsford, N.Y.**

For more details circle #195 on mailing card.

Malt Flavored Syrup Instant and Economical

The new Pet Instant Malt Flavored Syrup costs less than malted milk powder, will not cake or harden and is not affected by humidity. The syrup does not need refrigerating and is supplied in gallon jugs and quart decanter bottles, each with a preset dispenser pump. **Pet Milk Co., Arcade Bldg., St. Louis 1, Mo.**

For more details circle #196 on mailing card.

Prefabricated Piping System for Steam and Hot Water

Plasti-clad is the name given to a new, prefabricated piping system for the overhead distribution of steam, hot water and similar lines. It consists of the pipe and insulation covered with aluminum foil, over which are two wrappings of fiberglass cloth integrated within the Plasti-clad material and finish. The entire system is prefabricated complete with expansion loops, anchor units, elbows and "T" units, ready for installation. Also prefabricated is the new Plastic Coated system for underground distribution, con-

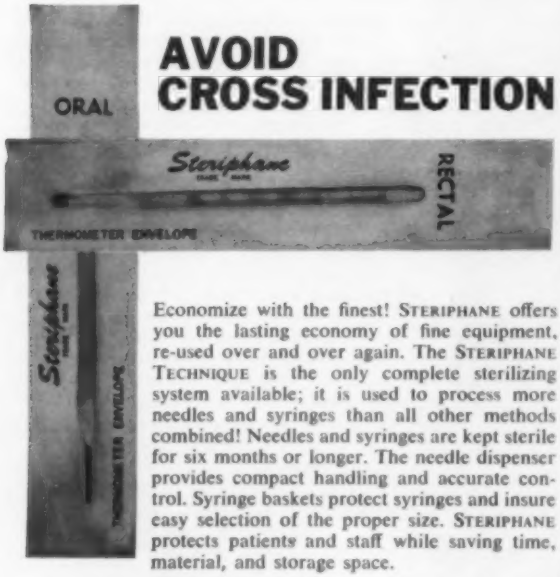
sisting of pipe and insulation covered by a spiral welded metal conduit protected against soil and stray current corrosion by an epoxy coating which resists acids, alkalis and salts. **Ric-wiL, Inc., Barberton, Ohio.**

(Continued on page 214)

Meet your Shelby Representative!

He's no ordinary printing salesman, for underneath this hat you'll find a great deal of know-how about the record-keeping operations of today's modern hospital. He sells more than paper and ink... he solves problems, helps you reduce paper work, cut record keeping time and, more often than not, can save you money on your printed forms. His office is nearby. Call him or write:

THE SHELBY SALESBOOK COMPANY, SHELBY, OHIO



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Economize with the finest! STERIPHANE offers you the lasting economy of fine equipment, re-used over and over again. The STERIPHANE TECHNIQUE is the only complete sterilizing system available; it is used to process more needles and syringes than all other methods combined! Needles and syringes are kept sterile for six months or longer. The needle dispenser provides compact handling and accurate control. Syringe baskets protect syringes and insure easy selection of the proper size. STERIPHANE protects patients and staff while saving time, material, and storage space.

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For additional information, use postcard facing back cover.

Redesigned Inspection Table Has Shadowless Panel

The shadowless inspection panel on the new #7502 MacBick Linen Inspection Station was developed by MacBick designers in close cooperation with Sylvania and Corning engineers. Time saving with careful linen inspection are ensured by the uniformly illuminated work surface on which gowns, sheets, surgical linens and the like can be checked for pin holes, tears and snags. Work surface flanges and edges are of White Formica with the

front surface and end panels of natural birch. The square-tubing frame has adjustable feet. **The MacBick Co., 243 Broadway, Cambridge, Mass.**

For more details circle #198 on mailing card.

Premiere Vina-Lux Flooring Has Fleecy Cloud Effect

A new manufacturing process makes possible a special pattern in vinyl asbestos tile. Developed by Azrock, the Premiere Series has a fleecy cloud effect which is distributed uniformly over the surface and throughout the full thickness of the tile. It comes in seven colors with tinted-white backgrounds, including two metallics. **Azrock Floor Products Div., Uvalde Rock Asphalt Co., Box 531, San Antonio, Texas.**

For more details circle #199 on mailing card.

Peppermint Stripe Bedspread Requires No Ironing

Available in three sizes, the new Peppermint Stripe bedspread has fresh-looking colored striping woven on a snow white crinkled ground fabric. It is machine washable, may be tumble-dried, and needs no ironing. It is finished with square corners and a plain hem and is available with white, pink, blue, sand or green stripes. **Morgan-Jones, Inc., Contract Div., 404 Fifth Ave., New York 18.**

For more details circle #200 on mailing card.

Just Cleaning Solution Disinfects and Deodorizes

Just Cleaner-Disinfectant produces thousands of "power bubbles" to lift out dirt, grime and deeply embedded soil and suspend it in solution for rinsing away, without harming surfaces. The increased phenol coefficient makes the solution effective against bacteria, spores and fungus so that it disinfects and deodorizes as it cleans. **Associated Just Distributors, Inc., 702 S. Wolfe St., Baltimore 31, Md.**

For more details circle #201 on mailing card.

Compact Can Crusher Operates Quietly

Quiet enough to use adjacent to serving and work areas, the new Herlex Hydraulic Can and Bottle Crushing machine is compact and readily mobile, rolling easily to location and out of the way when not in use. It crushes cans pancake flat and pulverizes bottles to take minimum space in waste cans. The machine is completely hydraulic, with no grinders or rollers, and

is ruggedly engineered for heavy daily use. **Herlex Sales Co., 1440 W. Van Buren St., Chicago 7.**

For more details circle #202 on mailing card.

(Continued on page 216)

Type "R" Steel Signs on Sipco Dunking Stations

A new Model No. 4J-R is added to the Sipco Dunking Station line of "safe

smokers." Designed to be placed at doors and elevators, in corridors, lounges and other areas in the hospital, the units are easily mounted permanently and are cleaned by removing the glass fiber inner liner. The new type "R" rectangular steel signs are made of heavy gauge steel with black lettering on a white background, available with any of six different wordings to encourage safe disposal of cigarettes and cigars. The No. 4J-R is offered with either Deluxe Bright polished or Duo-Tone gray crinkle finish. **Standard Industrial Products Co., 3527 Farmington Rd., Peoria, Ill.**

For more details circle #203 on mailing card.

Van Console-Conveyor Introduced at Restaurant Show

The Van Console-Conveyor, to be shown for the first time at the restaurant meeting in Chicago, is a lightweight package unit available in any length or turn required for speed, efficiency and convenience in soiled dish handling or patient tray set-up. All surfaces in contact with the conveyor belt are of rust-free stainless steel, neoprene or phenolic, and stainless steel is also used for pan and cabinet construction. The idler, take-up and end drum roller are equipped with heavy duty machined nylon bearings, and a safety switch stops the belt in case of jamming by personnel or tableware. **John Van Range Co., 5th and Butler Sts., Cincinnati 2, Ohio.**

For more details circle #204 on mailing card.

Hydro-Vac Cleaner Has Staphicidal Filter

Designed to collect and kill staphylococcus aureas and other types of bacteria, the new Hospital Hydro-Vac Vacuum Cleaner has a germicide-treated "Staphicidal" filter. The filter collects bacteria and other particles as small as 0.2 microns and traps and kills them in 190 cubic inches of polyurethane foam which is treated with a glycerol solution containing a high potency phenolic germicide. The filter is quickly and easily removed from the machine and can be washed, sterilized with boiling water or steam, and retreated with germicide for re-use. The new Hydro-Vacs are available in twelve different models. **Advance Floor Machine Co., Spring Park, Minn.**

For more details circle #205 on mailing card.

Glass Tinting in Colors Reduces Glare and Heat

Window and structural glass areas, and even automobile windshields, can be easily

tinted to cut down on glare and heat and protect against sun-fading. Nine transparent color tints and three frosted tints are offered in the plastic coating which is applied by a flow technic and operates in the same manner as an optical filter. The coating bonds to the glass chemically and the color appears to be within the glass itself. **Acorn Glass Tint, 1123 W. Century Blvd., Los Angeles 44, Calif.**

For more details circle #206 on mailing card.

(Continued on page 218)

Automated-Dishwashing System Has Klenztronic Controller

A simple, rugged, electronically controlled feeder and a new type liquid detergent make up the Klenzmation Automatic-Dishwashing System. The Klenztronic Controller is connected to a sensing probe in the dish machine tank and actuates an injector when the detergent concentration in the wash water falls below a predetermined level. Klenzmate Detergent is automatically fed from the container to assure effective cleansing at all times. No manual measuring, transfer or handling of detergent is required, thus preventing waste and error. **Klenzade Products, Inc., Beloit, Wis.**

For more details circle #207 on mailing card.

Fire Guard Lay-in System Speeds Installation

Combining the advantages of the earlier Armstrong Fire Guard tile ceilings with

the installation speed and economy of an exposed grid suspension system, the new Fire Guard lay-in system provides a fast and economical means of installing fire protection and a finished acoustical ceiling at the same time. The fire resistant ceiling panels, approximately two by four feet in size, rest in a unique type of exposed grid suspension specially designed to withstand the intense heat of fire, and can be lifted out for access to plumbing lines, air conditioning ducts and other concealed utilities. The Fire Guard ceiling panels are able to withstand exposure to direct flame and 2000 degree heat, and the system is specially designed to prevent the supporting metal grid from buckling or twisting during exposure to fire. **Armstrong Cork Co., Lancaster, Pa.**

For more details circle #208 on mailing card.

Cafeteria Counters in Enameled or Stainless Steel

Available in 18 gauge steel, enameled or stainless as desired, the new series "27" cafeteria counters replace two earlier models. The 26½-inch wide tops are flanged down flush against the body on all four sides. A deluxe model is also available with a 29¼-inch top. **Duke Mfg. Co., 2305 N. Broadway, St. Louis 6, Mo.**

For more details circle #209 on mailing card.

Melamine Dinnerware Has Cups to Match

Decorated cups are now available to match the four melamine dinnerware patterns in the Regal Decorated line. The dinnerware is safe in dishwashers or scalding water as the patterns are molded in and cannot fade or wear away. **Plastics Manufacturing Co., 2700 S. Westmoreland Ave., Dallas 33, Texas.**

For more details circle #210 on mailing card.

Clean-O-Magic All-Purpose Cleaner in Pre-Measured Plastic Bag

One pre-measured plastic bag of Clean-O-Magic is dropped into a gallon of water to produce one gallon of liquid concentrated cleaner with no dipping or measuring required. The concentrate is used to make from 30 to 40 gallons of cleaning solution with a high bactericide quality. Storage requirements are at a minimum and supplies of the plastic packages can be kept in various areas most convenient for

maintenance crews. **Scaletty-Corydon Co., 2649 Lyndale Ave. S., Minneapolis 8, Minn.**

For more details circle #211 on mailing card.

(Continued on page 220)

Automatic Scrubber is Self-propelled

Self-propelled, with no cords, fumes or odors, the new battery powered Auto-Scrubber Model 721-B features a rugged frame and case, large water capacity and

full floating brush and squeegee. It is easily maneuvered and will turn in its own length. The cleaning solution is metered for economic and thorough cleaning. **Lincoln Floor Machinery Co., 518 S. St. Clair St., Toledo 3, Ohio.**

For more details circle #212 on mailing card.

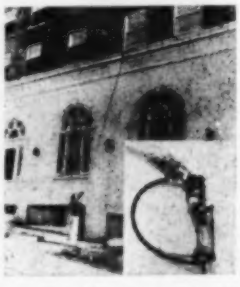
Rectal Medication and Application in Single Rectalyt Unit

A rectal medication supplied in a convenient, disposable Rectisert, Rectalyt is a new water-miscible polymer vehicle containing hydrocortisone and the new Sulfonamide, Sulfauridin. It is supplied in a soft plastic, disposable, measured, uniform single dose container-applicator. The physical nature of Rectalyt causes it to be adherent to all surfaces, wet or dry. It controls inflammation, facilitates wound repair and is anesthetic. It is easily administered and fingers never touch the medication. **Doho Chemical Corp., Mallon Div., 100 Varick St., New York 13.**

For more details circle #213 on mailing card.

Tucker Window Washers Add Two High Models

Two new models are available in the Tucker line of window washers for upper floors. While the operator remains safely on the ground, the new models will reach to heights of 76 feet and wash windows efficiently. Operated by one man, the

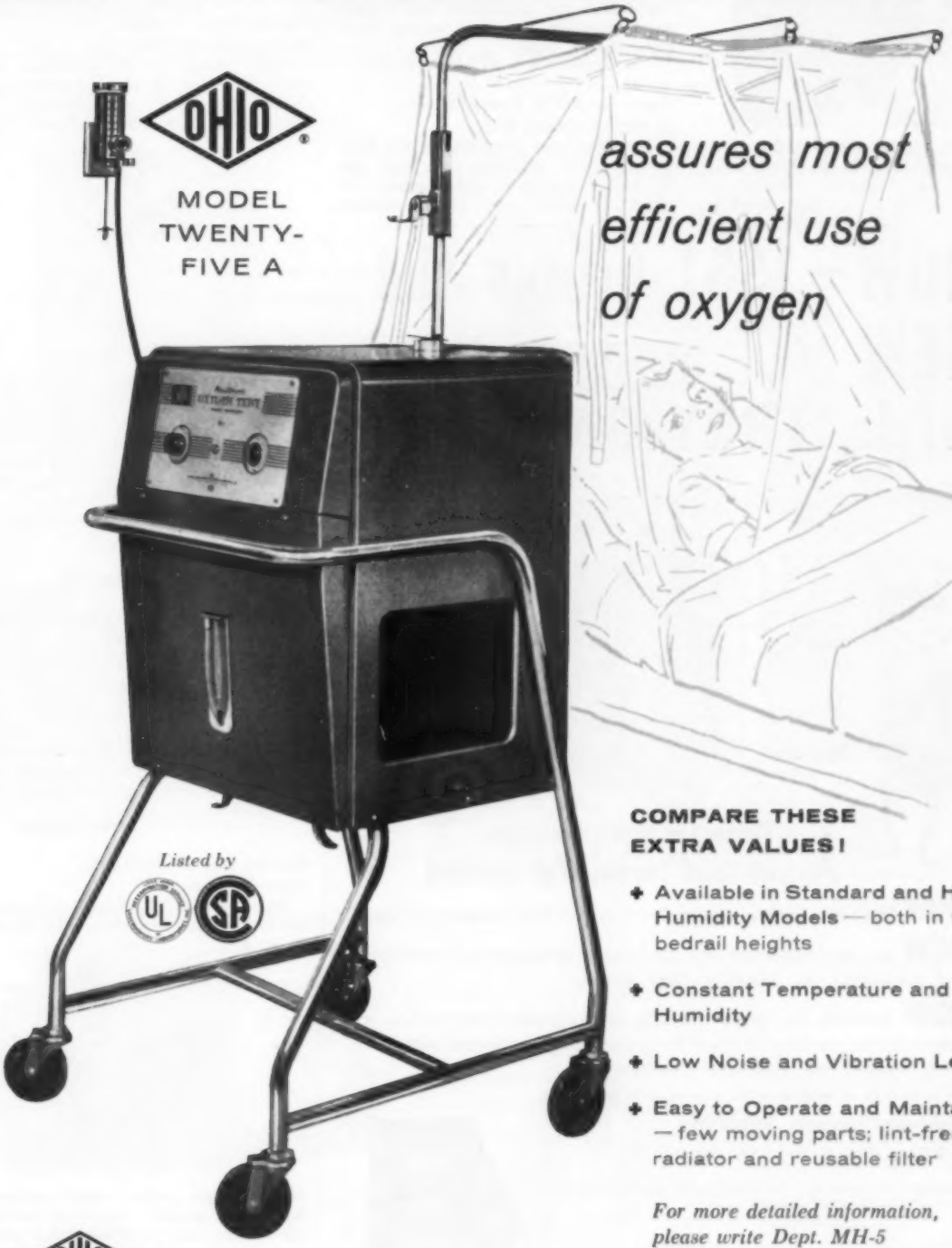


washers have telescoping handles with brush and detergent dispenser which regulates the flow of detergent or rinse water. Special wide flaring brushes clean large, small or rough windows and trim. The handles can be reduced or separated into sections for washing lower level windows. **Tucker Mfg. Co., Cedar Rapids, Iowa.**

For more details circle #214 on mailing card.

(Continued on page 222)

OXYGENTENT



assures most efficient use of oxygen

COMPARE THESE EXTRA VALUES!

- **Available in Standard and High-Humidity Models** — both in three bedrail heights
- **Constant Temperature and Humidity**
- **Low Noise and Vibration Level**
- **Easy to Operate and Maintain** — few moving parts; lint-free radiator and reusable filter

For more detailed information, please write Dept. MH-5 requesting Catalog 4780

OHIO *Ohio Chemical*

OHIO CHEMICAL & SURGICAL EQUIPMENT CO., MADISON, WIS.; OHIO CHEMICAL PACIFIC CO., BERKELEY, CALIF.; OHIO CHEMICAL CANADA LIMITED, TORONTO, ONT.; AIRCO COMPANY INTERNATIONAL, NEW YORK CITY (Divisions or subsidiaries of Air Reduction Company, Inc.)

Autocall "800" Central Sending Stations

New for 1961 in Autocall paging systems is the "800" Series Central Sending

Stations for use by switchboard operators and receptionists. The precision coding mechanism is housed in a walnut case with brushed aluminum face panel and code call numbers and other detail in etched black. The unit is available in capacities of 15, 30 and 45 coded calls. In addition to its basic function of locating key people quickly, the new system, with a selective Coding feature, can be set to give any one of four basic messages in code to the person paged. All calls are confidential and installation and maintenance costs are low. **The Autocall Company, Shelby, Ohio.**

For more details circle #215 on mailing card.

Super Singlefold Towel Cabinet Is Multi-Capacity Unit

No. 564 Super Singlefold Towel Cabinet, for use in washooms with heavy traffic, has a capacity of approximately 1300 singlefold towels. Fort Howard research in cabinet design produced a cabinet interior with improved dispensing so that the heavy load of towels can be inserted without the total weight resting on the bottom towel. Servicing time is cut by as much as 75 per cent. **Fort Howard Paper Co., Green Bay, Wis.**

For more details circle #216 on mailing card.

Bantam-Sized Vacuum for Wet and Dry Pick-Up

Small enough to go anywhere, yet powerful enough to do any institutional cleaning job quickly and efficiently, the new General Bantam-Size Industrial Vac-

uum Cleaner weighs only 27 pounds. It can recover seven gallons of liquid or ½ bushel of dry material and can be immediately converted to inside bag collection without the operator's hands touching the dirt. **General Floorcraft, Inc., 3630 Rombouts Ave., Bronx 66, N.Y.**

For more details circle #217 on mailing card.

All-Purpose Chair Can Be Stacked and Ganged

Royalwood, a built-up laminate of many layers of plastic impregnated wood which is resistant to damage by burning, mild acids, alkali, alcohol and weather, is used to form the new Model 746 Royal chair with Royalchrome all welded steel frame. The chair is lightweight, easily carried or moved, wipes clean, is contour-shaped for comfort, and can be stacked for storage or ganged for special uses. **Royal Metal Mfg. Co., One Park Ave., New York 16.**

For more details circle #218 on mailing card.

Folding Leg Utility Tables Stack for Storage

The new Rol-Fol folding-leg, Formica-top utility table features a steel channel

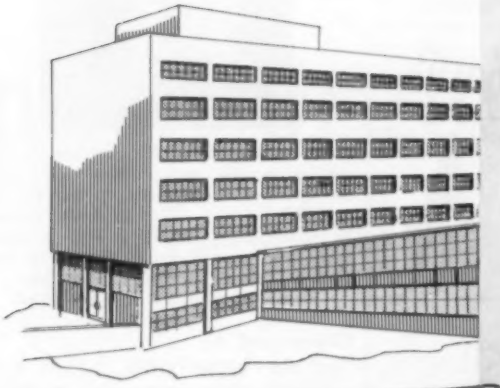
uniframe with sockets which anchor the legs when opened, eliminating the need for bracing and providing fuller seating capacity. The legs fold completely into the uniframe channel for flat stacking in storage. The table is available in a variety of shapes and sizes. **Rol-Fol Sales Co., 8467 Melrose Pl., Los Angeles 46, Calif.**

For more details circle #219 on mailing card.

(Continued on page 224)

No. 27 CLOSER solves door control problem at New York Univ. Medical Center in two-year test installation

"The first door control to stop glass breakage caused by strong East River winds..."
says **P. W. Barton,** CONSTRUCTION COORDINATOR



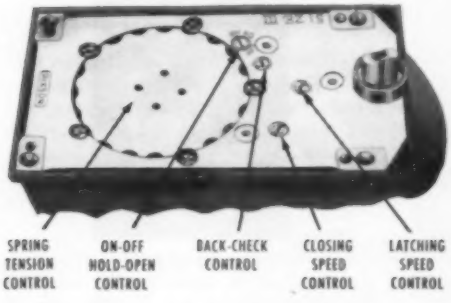
RIXSON® no. 27

TWO-YEAR FUNCTIONAL TESTS UNDER EXTREME CONDITIONS

This is one of twenty-two test installations of the No. 27 made approximately two years ago in locations throughout the U.S. and Canada where wind and other conditions were exceedingly severe.

Skidmore, Owings and Merrill, Architects

A COMPLETELY NEW DOOR CLOSER DESIGN
no. 27 offset hung **no. 28 center hung**



These New York University Medical Center south entrance doors are exposed to powerful East River winds which blow from *both directions.* Before the No. 27 closers were installed there was frequent glass breakage and closer damage.

The back-check of the No. 27 closers, locally adjusted for *firm* resistance, together with the positive dead stop, now keep the opening action of these doors under constant control. The closing action of the doors is under dependable hydraulic check with closing and latching speeds each independently adjusted to cope with the wind conditions.

Complete literature and details on the No. 27 offset hung and No. 28 center hung closers will be mailed on request.

THE OSCAR C. RIXSON COMPANY

9100 west belmont ave.
franklin park, illinois

CANADIAN PLANT:
43 Racine Road
(Rexdale P.O.) Toronto, Ont.

For additional information, use postcard facing back cover.

Small Food Mixer Has One Lever Control

Designed for hospital and other institutional kitchens which require a small food mixer, the Triumph N1-20 has single lever control with smooth variable speed selection. The 20-quart mixer is available in floor and bench models and is easy to clean. **The Triumph Mfg. Co., 3400 Spring Grove Ave., Cincinnati 25, Ohio.**

For more details circle #220 on mailing card.

Waterproof Walls for Tub and Shower

Durable, easy cleaning new waterproof walls for tub-and-shower enclosures in institutions are supplied in simple self-sufficient installation packages or as panels. Two layers of Micarta laminate bind an inner core of moisture-resistant foamed polystyrene to form the walls which will not chip, crack or fade in use. **Micarta Division, Westinghouse Electric Corporation, Hampton, S.C.**

For more details circle #221 on mailing card.

Hot and Cold Foods From Same Vender

A new automatic vending machine which can sell foods and merchandise in a temperature range of around zero to 155 degrees F. is introduced by Vendo. Little more than half the size of a stenographer's desk, the Visi-Vend is six feet five inches high. It offers up to ten selections of items, hot or cold, each visible through a

glass serving door. Six models of the vender include the dual-control model for frozen and hot foods, models for all-cold, all-hot and all-frozen items, as well as room temperature items from a model without thermal controls. **The Vendo Co., 7400 E. 12th St., Kansas City 26, Mo.**

For more details circle #222 on mailing card.

Compressed Air Operates Surgical Drill

Entirely air-powered and explosion-proof, the new Michelson-Sequoia Surgical Air Drill is completely free from electrical connections. It provides finger-tip control of precise cutting burs and drills rotating at smooth, vibration-free speeds of from 0 to 60,000 rpm. The simple unit consists of a hand piece and bur weighing in the neighborhood of seven ounces and connected to the control box by lightweight plastic tubing which delivers the air pressure. **V. Mueller & Co., 330 S. Monroe St., Chicago 12.**

For more details circle #223 on mailing card.

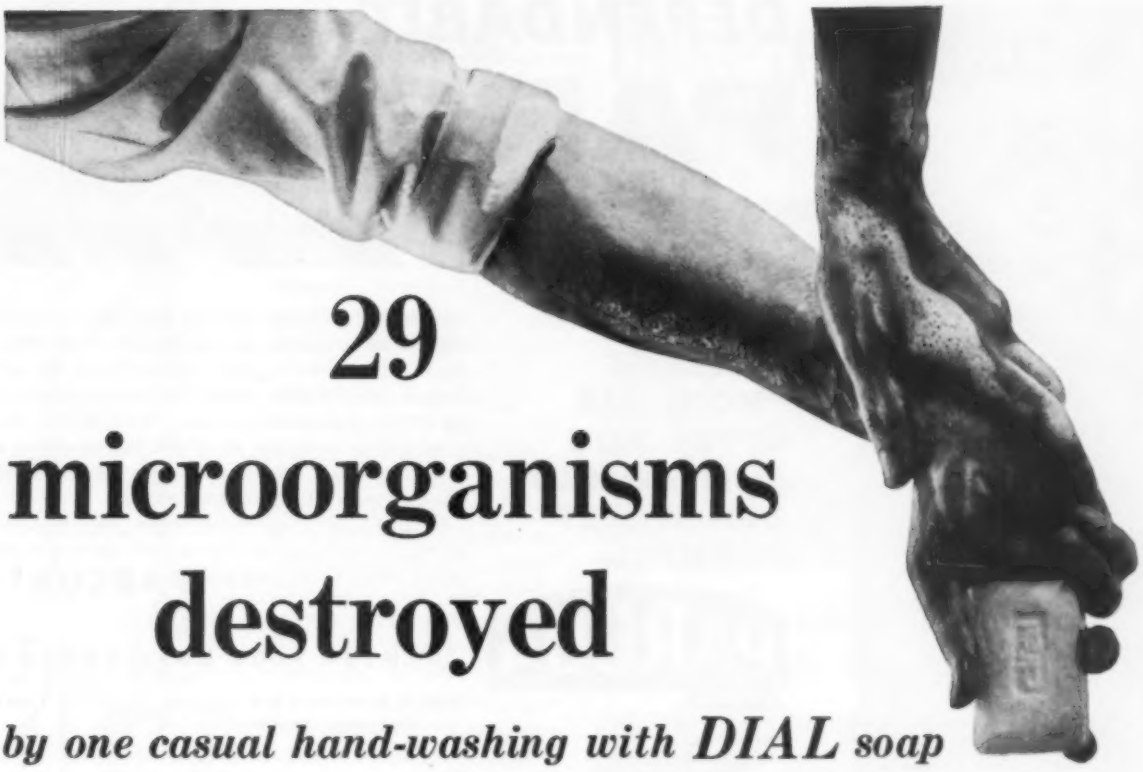
Contoured Urinal Especially for Female Patients

A specially contoured urinal, specifically patented for female use, adapts to the female body for comfortable leakproof use without the assistance of a nurse or

other attendant. Molded of unbreakable plastic which is warm to the touch, it can be autoclaved and is stain resistant and odor and noiseproof. It has a capacity of 1000 c.c. in horizontal position or 1600 in vertical position. **Plasta-Medic Mfg. Inc., 10 W. Dayton St., Pasadena, Calif.**

For more details circle #224 on mailing card.

(Continued on page 228)



29 microorganisms destroyed

by one casual hand-washing with DIAL soap

Routine use of Dial by patients and personnel suggested as an aid in eliminating one source of infection

New and more extensive tests have established that Dial soap destroys a wider range of gram-positive and gram-negative microorganisms, and controls their growth, than any other bar soap designed for hospital use. Latest tests show that Dial is effective against 29 strains with a casual hand-washing. These organisms include *six strains of Staph aureus*, along with others which resist antibiotics.

The antibacterial ingredient in Dial—a synergistic combination of hexachlorophene and trichlorocarbanilide has long been known for its effectiveness against skin bacteria that cause perspiration odor. Dial's antibacterial properties have been familiar to physicians for a considerable time. And now, this new evidence sharply points up the benefits of Dial for routine use by hospitalized patients and hospital personnel.

With its unique antibacterial benefit you might expect to pay extra for Dial—but you don't. You can trim costs even more by choosing the bar sizes suited to your hospital needs. Three hospital-tested sizes are available—1, 1¼ and 2½ oz.—also others. Write our laboratory at address below for technical and clinical information.

Antibacterial spectrum of Dial soap

Microorganism	Soap Concentration For Total Kill, ppm* Dial
1. S. aureus (No. 209) **	10
2. S. aureus 388010 ***	10
3. S. aureus 388014 ***	25
4. S. aureus 388062 ***	25
5. S. aureus 388115 ***	10
6. S. aureus 388128 ***	10
7. S. lutea	3
8. E. coli	5000
9. S. oranienburg	4000
10. S. typhosa	9000
11. S. pullorum	4000
12. P. mirabilis	6000
13. P. vulgaris	8000
14. S. marcescens	4000
15. S. flexneri	5000
16. P. fluorescens	9000
17. B. cereus	10
18. B. megaterium	10
19. B. s. v. niger	25
20. B. s. v. atterimus	10
21. B. ammoniagenes	10
22. S. faecalis	25
23. M. phlei	10
24. M. smegmatis	10
25. N. catarrhalis	10
26. C. albicans	4000
27. S. cerevisiae	4000
28. T. interdigitale	50
29. Airborne mold	1000

*Soap concentration: Casual handwashing: 80,000 ppm (average); deliberate scrub: 120,000

**F. D. A. Strain (biological standard).

***Antibiotic-resistant strains supplied thru the courtesy of Mt. Sinai Hospital, New York, New York.

from the Industrial Soap Division of

ARMOUR AND COMPANY

1355 W. 31st Street, Chicago 9, Illinois

For additional information, use postcard facing back cover.

Compact Floor Machine Has Increased Use

Supplementing its previous versatility, the Super Service Port-Able 13SP floor machine is now equipped with a solution tank for scrubbing and shampooing carpets and rugs. The tank of high impact

Styrene provides light weight with strength and durability. Built especially for small area duty, the machine has a cast aluminum brush skirt and standard aluminum drive plate for the 13-inch brush. **The National Super Service Co., 1945 N. 12th St., Toledo 2, Ohio.**

For more details circle #225 on mailing card.

Balloon Catheter Closure Saves Costs

Developed at the request of hospitals, urologists and surgeons, the Balloon Catheter Closure serves a four-fold purpose: to reduce closure costs; to provide a closure to be safely used in x-ray work; to create a positive closure for assured retention, and to save costs of sutures, hemostats and clamps. It permits pre-placement of the closure on the catheter, prior to injection of water, for one-man operation. Made of tough fiber, it may be autoclaved, but the cost permits disposing of it after one use. **United Surgical Supplies Co., Inc., 154 Midland Ave., Port Chester, N.Y.**

For more details circle #226 on mailing card.

Rol-Away Aluminum Truck Has Center Pivot Wheel

Designed expressly for hospital use, the Model HD-1 Rol-Away multi-purpose aluminum truck is compact, lightweight and easily maneuvered. A Rol-Guide center pivot wheel, controlled by a foot lever, gives the truck rigid stability when

stopped. When the pivot wheel is retracted, the truck moves on corner-mounted six-inch rubber tired wheels. Three open trays and seven drawers, plus the full top area, permit transporting a large quantity of supplies. **Rol-Away Mfg. Co., 6143 S.E. Foster Road, Portland 16, Oregon.**

For more details circle #227 on mailing card.

(Continued on page 230)

Blankets of Acrilan* roll into more New York Hospitals

Brooklyn Jewish Hospital and The Home for The Aged and Infirm Hebrews of New York have joined a growing group of hospitals who are using blankets of **100% virgin Acrilan acrylic fiber.** Here's why:

These extremely durable blankets give warmth without cumbersome weight. They can be machine washed and machine dried, fresh and ready for the bed in one hour. Blankets of 100% virgin Acrilan resist shrinking and won't lose their original shape or luxury after washing. Your need for extra replacements is greatly reduced.

And these blankets are non-allergenic and contain no elements that attract insects. More and more hospitals are discovering this remarkable blanket.

Blankets of 100% virgin Acrilan are ready for a long stay in your hospital.

ACRILAN
ACRYLIC FIBER
*Reg. T.M. of Chemstrand

Chemstrand has licensed this "A"-Acrilan trademark as an ingredient trademark for those fabrications that provide utility, function and consumer value. In order to obtain a license to use this trademark, the fabrications must meet certain rigid specifications as established by The Chemstrand Corporation.

Chemstrand makes only the fiber; America's finest mills do the rest.

THE CHEMSTRAND CORPORATION • GENERAL SALES OFFICES: 350 FIFTH AVE., NEW YORK 1, N. Y. • DISTRICT SALES OFFICES: 350 Fifth Ave. New York 1; 3½ Overwood Rd., Akron, Ohio; 197 First Ave., Needham Heights, Mass; 129 West Trade St., Charlotte, N. C.; California Office: 707 South Hill St., Los Angeles 14. Canadian Agency: Fawcett & Co., 34 High Park Blvd., Toronto, Canada • PLANTS: ACRILAN* ACRYLIC FIBER—Decatur, Ala.; CHEMSTRAND* NYLON—Pensacola, Fla.

BMI Precut Cards for Patient Identification

Precut, preprinted and color coded BMI Cards are introduced to save time and cost in patient identification for chart holders. The cards are supplied in packages of 1000, fit neatly into a BMI Dispenser, and are ready to tear off and slide into a chart label holder. The Dispenser has a stainless steel case with a cutting edge and good writing surface. **Beam Metal Specialties, Inc., 25-11 49th St., Long Island City 3, N.Y.**

For more details circle #228 on mailing card.

Waxless Floor Finish Is Bacteriostatic

Residual bacteriostatic properties in Plexin floor polish continue to retard bacteria growth as long as the polish is on the floor. Independent laboratory tests show the bacteria-proofing action. Plexin is a self-polishing, non-skid floor finish, applied with applicator or mop, to wood, terrazzo, marble, cork, rubber, linoleum, asphalt, vinyl or other composition tile floors. It is scuff-resistant and easily maintained by routine buffing. **Puritan Chemical Co., 916 Ashby St., N.W., Atlanta, Ga.**

For more details circle #229 on mailing card.

Univex Stands and Carts for Food Preparation Rooms

Several additions to the Univex line of food handling equipment will add flexibility in institutional kitchens. A new mobile stand designed for peelers permits peeling machines to be wheeled to the sink for use, saving counter space and eliminating lifting. Other Univex food machine stands, in addition to mobility, provide tops that can be adjusted in height for the convenience of the operator and the most efficient use of the particular machine it holds. The new Mixer Accessory Stand illustrated, Model E-240-A, is two feet in width and depth, die-formed of heavy gauge steel, galvanized or stainless, with telescopic legs which adjust from 24 to 36 inches high. It is available with or without casters and provides both a stand for any type or make of bench mixer, and a well-fitted,

enclosed storage cabinet to organize all attachments for the mixing machine in one place. **Universal Industries, Somerville, Mass.**

For more details circle #230 on mailing card.

Super-Edisonite Is Effective, Safe Cleanser

Economy in use, mildness to skin and delicate instruments and extra fast dissolving action are advantages claimed for the new, improved Super-Edisonite cleanser for surgical instruments and glassware. The high-potency formula makes an effective solution with a single tablespoon of powder per gallon of warm tap water. The cleanser is effective on a wide range of materials and cleans delicate instruments without tarnishing, pitting or corroding. It is available in two sized packages, both with direct pouring spout for dispensing. **S. M. Edison Chemical Co., Inc., 2710 S. Parkway, Chicago.**

For more details circle #231 on mailing card.

Carnival Pattern Is Custom-Colored

Custom-colored to individual requirements, Carnival china is offered in several standard two-color combinations. It is available in two shapes, the Revere for space-saving on tray or table, and the Narrim. **Walker China. Bedford, Ohio.**

For more details circle #232 on mailing card.

(Continued on page 232)

Lustro-Ware Refuse-Tainers Have Handle Locks

Positive closure and easier handling of Lustro-Ware polyethylene refuse-tainers is provided with the "Flip-action" steel handle locks now available on four models. Sizes include the eight-gallon rectangular container, and round fluted containers in six, 12 and 24-gallon sizes. **Columbus Plastic Products, 1625 W. Mound St., Colmbus 4, Ohio.**

For more details circle #233 on mailing card.

Name Plate System Speeds Admissions and Records

Record and accounting procedures in the hospital can be simplified with a new one-step form, plus plastic card, which also speed admissions. An electrically powered manual embossing machine, the Dashew Datatyper 400 produces plates that provide clear impressions for automatic character reading. The machine is simple to operate and its new keyboard concept permits high speed production with a minimum of errors. It operates as quietly as a typewriter, is lightweight and portable, and permits the making of permanent copies of admitting information for use in various departments for the many services required. The Datatyper 400 is available with four interchangeable embossing type styles, and may be equipped with a code punching unit which provides machine language coding into the identification card for subsequent use in the Dashew Printapunch for direct input into data process-

ing. **Dashew Business Machines, Inc., 3655 Lenawee Ave., Los Angeles 16, Calif.**

For more details circle #234 on mailing card.

Coin-Operated Dry Cleaner Operates Automatically

Economy, time savings and quality cleaning are claimed for the new Whirlpool coin-operated drycleaner. The machine is simple to operate and each unit is a self-contained drycleaning plant which operates on conventional 220-volt current. It is designed to clean up to eight pounds of clothes automatically in 50 minutes. The cycle includes washing with a non-flammable perchlorethylene solvent that is continually filtered, extraction of the solvent, controlled heat tumbling for drying, and deodorizing by air circulation. Clothes are said to be ready for wear when removed from the unit. **Whirlpool Corp., St. Joseph, Mich.**

For more details circle #235 on mailing card.

"Hand-i-Maid" Linen Truck Folds for Storage

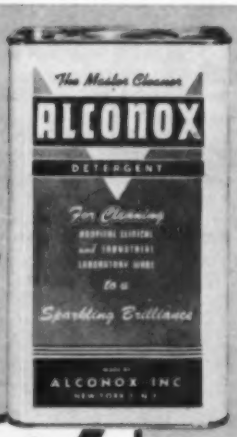
The "Hand-i-Maid" shelf truck for use by maids and for carrying linen is designed

to fold into little more space than an office chair for storage. Six wheels permit turning the truck in its own length and facilitate mounting or descending curbs. The cart is designed for hospital housekeeping and has three large shelves to carry bed and bath linen, plus two supply trays for cleaning items. A utility platform and side brackets hold cleaning equipment and space is provided for trash bags. **The Paul O. Young Co., Line Lexington, Pa.**

For more details circle #236 on mailing card.

(Continued on page 234)

THE WORLD'S FINEST DETERGENT



Proven the world's finest and most economical detergent for the exacting requirements of Hospital, Medical and Laboratory use.

MEETS HIGHEST U.S. GOVERNMENT SPECIFICATIONS

MORE WETTING POWER!

MORE SEQUESTERING POWER!

MORE EMULSIFYING EFFECT!

QUICKLY, COMPLETELY SOLUBLE AND RINSABLE!

More effective than any known detergent in powder form or any liquid detergent that costs four times as much!

ALCONOX
The Master Cleaner

Sold throughout the world!

ALCONOX announces with Pride its new Companion Line of

HOSPITAL BRAND H&L LABORATORY PRODUCTS

SUPERIOR SPRAY PRODUCTS for DOCTORS and HOSPITALS

COMPARE THESE PRICES for proof that nowhere in America can you duplicate such matchless low costs for products of such unquestionable quality in economy-size 12-oz. cans!

H & L Spray SKIN PROTECTOR
with Dow Corning Silicones

Formulated with the skin-soothing properties and protection of silicones and the bacteriostatic action of hexachlorophene to aid in the prevention of contact dermatitis, intertrego and miliaria among bed-ridden, incontinent patients and to prevent the subsequent formation of decubitus ulcers. Its use will minimize cross infection.

12-oz. Can, $1.65 ea. In case of 12 Cans, $1.45 ea. Per Case, $17.40

H & L Spray FREEZE *with du Pont Freon®*

For quick, temporary, topical anesthesia of the skin by freezing for minor surgery.

12 oz. Can, $2.18 ea. In Case of 12 Cans, $1.86 ea. Per Case, $22.32

H & L Spray ADHESIVE TAPE REMOVER

Removes adhesive tape painlessly, also any tape markings remaining.

12 oz. Can, $1.35 ea. In case of 12 Cans, $1.15 ea. Per Case, $13.80

H & L Spray BANDAGE *with Neomycin*

Provides a new method for the quick and easy application of a sterile, transparent, flexible film, which adheres to the surface of the skin, providing an obstacle to bacteria.

12 oz. Can, $2.30 ea. In Case of 12 Cans, $2.00 ea. Per Case, $24.00

H & L Spray U.S.P. TINCTURE of BENZOIN
In Aerosol

Improves adhesive properties of tape and minimizes patient's discomfort during long tape and cast applications. For the prevention of bed sores, we suggest H & L Skin Protector.

12 oz. Can, $2.00 ea. In Case of 12 Cans, $1.70 ea. Per Case, $20.40

H & L Spray ROOM DEODORANT

The outstanding sick-room deodorant. Kills odors chemically. Contains no masking agent.

12 oz. Can, $1.35 ea. In Case of 12 Cans, $1.15 ea. Per Case, $13.80

ASSORTED CASE 2 Cans of each of the above 6 Items **$18.80**

PRICES SLIGHTLY HIGHER WEST OF THE ROCKIES

ALL OF THE ABOVE PRODUCTS ARE SOLD BY THE DEALER TO YOU ON A 100% SATISFACTION GUARANTEE.

ORDER TODAY FROM YOUR SUPPLIER

ALCONOX and H&L PRODUCTS are sold by all leading Hospital, Laboratory and Surgical Dealers

Fountain Tracheotomy Device Consists of Two Tubes

A new type of tracheotomy tube was invented by Miss Josephine Fountain, a nurse at the University of Florida Hospi-

tal. Consisting of two tubes, one inside the other, with a small neck on the outside having two openings instead of one, the device facilitates clearing the throat of mucous and other obstructions and makes it safer and easier to administer anesthesia to tracheotomy patients requiring surgery. The device can also be used for administering oxygen and the inner tube can be removed for cleaning with little or no discomfort to the patient. **George Tieman & Co., 2128 45th Road, Long Island City 1, N. Y.**

For more details circle #237 on mailing card.

"Thermo-Fax" Visual Communications With Projection Transparencies

Plastic transparencies can be made from almost any document in less than ten seconds in normal light and projected immediately in a fully-lighted room with the new "Thermo-Fax" brand visual communications system. It combines the use of any existing "Thermo-Fax" copying machine and the new "Thermo-Fax" projector for fast, economical and efficient operation. The projector is a compact unit which can be moved easily from room to room and uses regular 110 volt current. No special training or complicated developing processes are required as the "Thermo-Fax" projection transparencies are made from plastic sheets without chemicals or solutions. The transparency is immediately ready for projection and is made from opaque, transparent or translucent originals printed on one or both sides. **Minnesota Mining & Mfg. Co., 900 Bush Ave., St. Paul 6, Minn.**

For more details circle #238 on mailing card.

16 Sided Grab Bars Give Added Safety for Patients

For installation in bathrooms, showers, toilets or wherever required to aid pa-

tients and to ensure safety, the functionally designed Polygrab Bars have a new gripping surface of 16 flat planes. They are especially designed for use by the aged or handicapped, in therapy centers, rest homes, hospitals for the mentally ill, schools and the like. All edges of the grab bar handle are slightly rounded and a specific type is available to meet every requirement. They are made in 12, 16 and 24-inch vertical or horizontal types as well as right and left 45-degree angle bars and right and left 90-degree horizontal and vertical grab bars. **Logan Hospital Equipment Co., Glendale, Calif.**

For more details circle #239 on mailing card.

Miniature Planning Kit for Automatic Cafeterias

Planning for automatic cafeterias is facilitated with the new Miniature Plan-

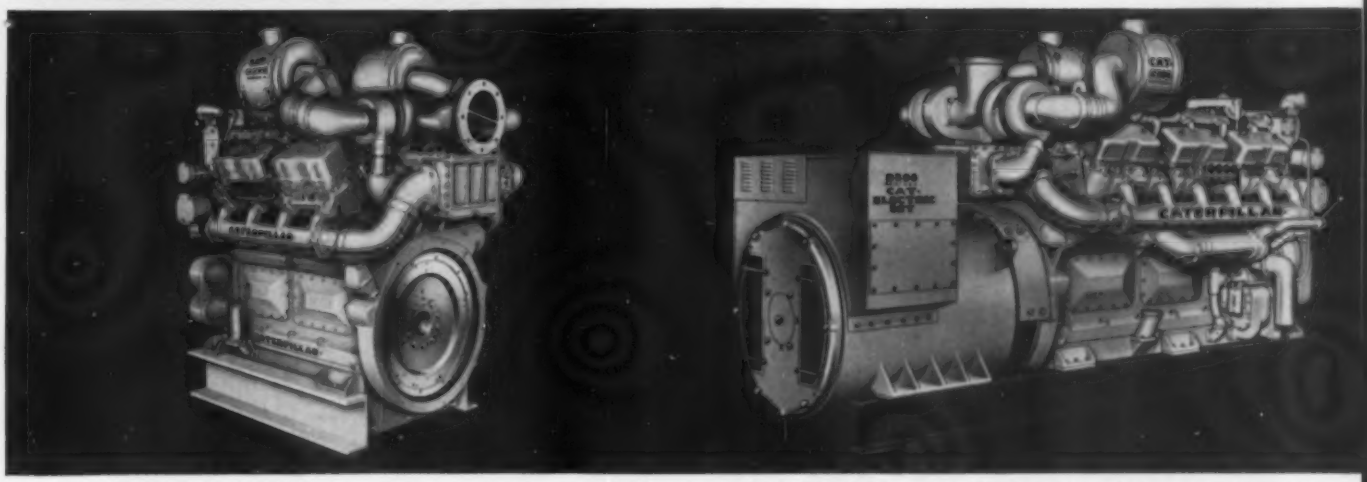
ning Kit developed by Rowe. Movable ½-inch scale photographic cut-outs of vending machines can be arranged to suit requirements for approximation of the amount of wall space required for groups of machines. Various arrangements of any number of machines in the Roweboteria line can be made with the kit. **Rowe Mfg. Co., 31 E. 17th, New York 3.**

For more details circle #240 on mailing card.

(Continued on page 236)

engine power BY CATERPILLAR

new Cat D398-D379



Cat D379 Industrial Engine. The 6.25" bore, 8.00" stroke D379 and D398 both offer the latest in attachments including marine gears and generators. The D379 Electric Set develops up to 350 KW continuous, 400 KW standby.

Cat D398 Electric Set. The D398 Electric Set shown here with Static-Regulated, Static-Excited Generator features a new generator with built-in static excitation system with no exciter generator or vibrating parts. Develops 500 KW continuous, 600 KW standby.

Give more horsepower per pound, per dollar than any other industrial engine in their class

The V12 D398 and the V8 D379 are rated at 950 and 630 maximum HP, respectively. Electric set versions reach to 600 and 400 KW. Marine ratings exceed 1000 HP. These engines are now available at prices that are less than crankshaft replacement prices of some competitive engines in their class.

Published list prices show the D398 to be thousands of dollars less than the next lowest priced industrial engine that will develop comparable horsepower. Other advantages are quality aluminum alloy bearings, aluminum pistons with cast-iron ring band for top two compression rings, drop forged-dynamically balanced crankshaft and high strength rigid block. These engines save in space and weight, too . . . with at least 35-40% less size and 4800 pounds less weight than other makes with comparable horsepower.

Here are more reasons why Cat D398 and D379 Diesels and Electric Sets give you extra value

NEW PERFORMANCE STANDARDS

- Turbocharged-Aftercooled design
- Static-Regulated, Static-Excited Cat Generators
- High flow lube and water systems
- Ability to burn wide range of fuels

NEW ENGINE FLEXIBILITY

- 100% HP from either end of engines
- Six available accessory drives – up to 50 HP each
- Controls available for either side
- Standard (counterclockwise) rotation or opposite rotation

NEW SERVICE EASE

- Fuel or lube filters serviced from either side
- Remove heads without disturbing manifolding
- Easily inspect or remove pistons, rods and bearings through large side ports
- Externally mounted oil pumps for easy inspection and maintenance

For complete specifications on the D398 and D379 Diesel Engines or Electric Sets, contact your Caterpillar Dealer or Caterpillar Engine Division, Peoria, Illinois.

CATERPILLAR

Caterpillar Tractor Co., Engine Division, Peoria, Illinois, U. S. A.

Portable Sitz Bath
Fits Standard Closet Bowl

Made of high-impact rigid vinyl with a smooth, easily-cleaned finish, the Glow Sitz Bath is a lightweight unit which fits

over the standard closet bowl. It comes complete with faucet connector and flexible hose, and flow and temperature of the water are easily regulated. The flat, wide seat is specially designed for full surface rest without circular pressures and the water supply is always clean, moving from the front to the back and out. It is designed for pre-operative and post-operative uses and other therapy in the perineal area. **Bel-Art Products, Pequannock, N.J.**

For more details circle #241 on mailing card.

Automatic Temperature Control
on Food Conveyor

Foods transported from central kitchens to serving areas are kept at the proper temperature in the new Atlas Model HP-1 Food Conveyors with automatic temperature control. The conveyor has a capacity of 70 quarts and provides a reserve supply of hot foods close to serving areas immediately ready to serve. **Atlas Div., National Cornice Works, 1323 Channing St., Los Angeles 21, Calif.**

For more details circle #242 on mailing card.

Open Shelf Power Files
Speed and Simplify Work

Electric powered floor to ceiling Diebold Open Shelf Power Files bring records to the user without stooping, stretching or straining and with savings of time and floor space. Designed to handle documents of any practical size, the files are available in three standard models. All shelves rotate in upright position, with a

three-second cycle between successive shelves, by the touch of a button. The units are ruggedly constructed and available in a variety of arrangements to suit the need, including sitting, standing or rolling desks, pushbutton controls or touch bar, locking doors, and colors to match the office. **Diebold, Inc., Canton, Ohio.**

For more details circle #243 on mailing card.

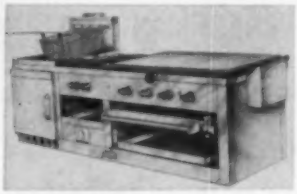
Mardi Gras Tile Colors
Go All the Way Through Material

Resilient, slip-resistant and easy to keep clean, Mardi Gras tile is made of Nyracord and designed to afford resistance to wear, scoring, denting and puncturing. Available in a choice of thicknesses and sizes, the tile is produced in five colors, which go all the way through the material so as not to show wear, with a "confetti" or stippled design. **American Mat Corp., 1719 Adams St., Toledo 2, Ohio.**

For more details circle #244 on mailing card.

Kitchen Unit
Performs Four Ways

The new 4-Way Cooker Model #1848-BR combines frying, cooking, grilling and broiling in one stainless steel unit, featuring the Golden Fryer which responds in-



stantly to the slightest temperature change, keeping fat at correct cooking heat. Easy to clean and simple to operate, the unit has a single gas supply for all four cooking functions. **Cecilware-Commodore Products Corp., 43-05 20th Ave., Long Island City 5, N. Y.**

For more details circle #245 on mailing card.

(Continued on page 238)

The custodian's gone home . . . *on time!*

Thanks to quality Geerpres equipment, custodians usually finish floor mopping on time. For regular scheduled floor maintenance or emergency clean-ups, the ease of operation and reliability of Geerpres equipment makes for better work in shorter hours.

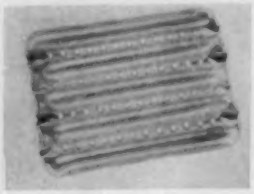
Geerpres makes no economy or "leader" line of products. We build only one quality—the best we can possibly make! Geerpres geared wringers, buckets, chassis, mop handles, mops and complete outfits are available in a wide range of sizes but only one quality . . . the finest.

See your Geerpres jobber now or write for Catalog 60.

Geerpres WRINGER, INC., P. O. BOX 658, MUSKEGON, MICHIGAN

Sanitary Wheel Chair Cushion of Inflated Vinyl

Constructed of vinyl plastic, the Aeropedic Wheel Chair Cushion is inflatable



to the desired thickness, and will not mat or pack down from perspiration or other moisture since it is non-absorbent. It is easily washed or disinfected and the design provides cool comfort while reducing pressure points. The elimination of slip covers reduces laundry costs. **The Howard Sales Co., 1938 E. Colorado Blvd., Pasadena, Calif.**

For more details circle #246 on mailing card.

Band-Aid Sheer Now Has Overall Air-Vents

Adhesive bandages with air-vents over both pad and tape areas are now available in the new Band-Aid Sheer Bandages. The air-vents let air circulate inside to dry the wound and promote speedier healing, and allow moisture to escape, reducing skin wilting and whitening. The new Band-Aids are available in professional 100's packages of ¾-inch and one-inch, plus new Sheer Patches and Spots. **Johnson & Johnson, New Brunswick, N.J.**

For more details circle #247 on mailing card.

Sequential Occlusion System For Emergency Cardiac Treatment

The Sequential Occlusion System offers an automated means of emergency treatment for patients with congestive heart failure by inhibiting the venous return, thereby pooling the blood in the extremities rather than in the lungs. The S.O.S. is a lightweight instrument, readily portable, and operates by a non-pulsating pump which provides constant flow and noiseless pressure, which is adjustable as

required. Acting as an automatic alternating tourniquet, the instrument operates on 110 volt, 60 cycles, and a simple dial setting activates it. **Electro-Medical Engineering Co., Inc., 703 Main St., Burbank, Calif.**

For more details circle #248 on mailing card.

Kato Motor-Generator for "No-Break Power"

Momentum for continuous power without break, in the event of failure of normal electric power, is provided with the new Kato Motor-Generator specially designed with a unique flywheel arrangement. The momentum of the large flywheel is designed to keep fluctuation to a minimum until the standby power plant is cut into the line. **Kato Engineering Co., Dept. R, Mankato, Minn.**

For more details circle #249 on mailing card.

Compact Kit For Replacing Faucet Seats

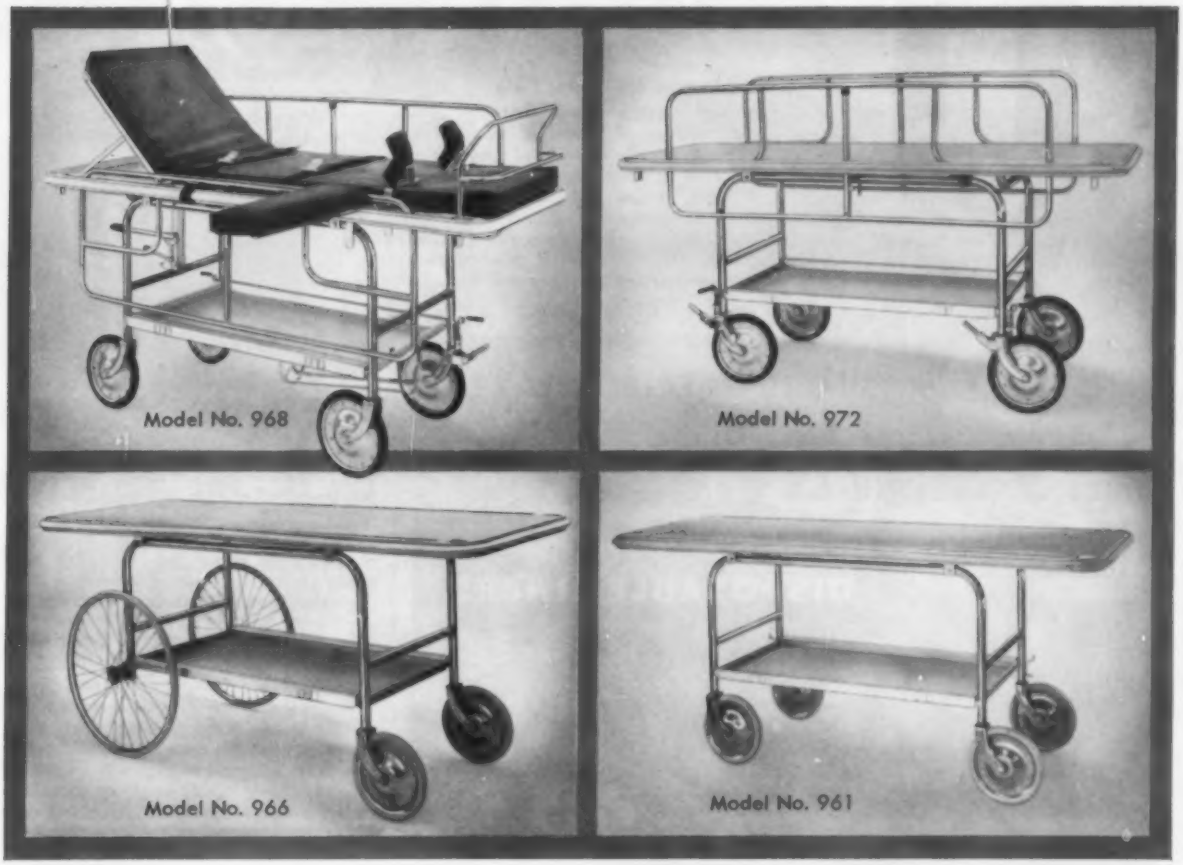
Thirty-five different types and sizes of Removable Full-Saddle Seats are available in the new Sexauer No. 24-B Handy Andy kit for replacing worn, pitted, water

cut or corroded removable faucet seats. The handy metal kit contains 100 assorted seats, three different sizes of wrenches, and a gauge providing 33 tappings for determining the exact type and size seat needed. The handy metal carrying case is divided into 20 tills, has a locking cover, and an index affixed to the inside identifies each part. **J. A. Sexauer Mfg. Co., Inc., 2503 Third Ave., New York 51.**

For more details circle #250 on mailing card.

(Continued on page 240)

Finer Equipment at Lower Cost!

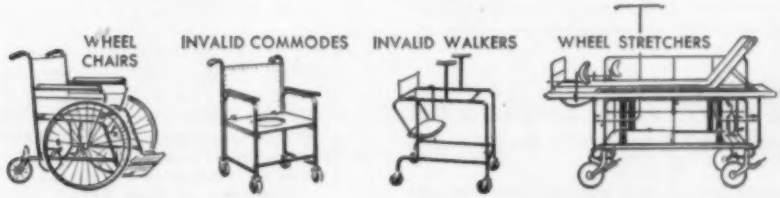


Gendron's Complete Wheel Stretcher Line

Yes, if it's a genuine Gendron, it's the finest of its kind, and at a cost to fit any hospital budget. This all-new Gendron wheel stretcher line has been designed and manufactured with the usual Gendron quality features with ruggedness, ease of handling and patient comfort foremost in mind.

Many features, including Gendron exclusives, such as 1¼ in. Steel Tubing throughout, are standard equipment. However, a complete line of accessories to assure proper patient care are available at a minimum additional cost. Write for Catalog #WS-61, or see your nearest Gendron supply dealer.

GENDRON . . . FOR OVER 85 YEARS THE QUALITY MANUFACTURER OF WHEELED EQUIPMENT FOR THE PATIENT OR THE HANDICAPPED



THE GENDRON WHEEL COMPANY
PERRYSBURG, OHIO

For additional information, use postcard facing back cover.

Nalgene Pipet Jars Molded in One Piece

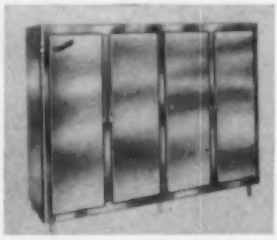
Blow-molded in one piece to provide a solid, leakproof receptacle with a minimum of locked-in stress, the new Nalgene Pipet Jars are designed with a slight flare at the top for easier insertion of the pipet basket. The unbreakable polyethylene provides natural resiliency to cushion the lab ware and prevent scratching, chipping or breakage of fragile contents. **The Nalge Co., Inc., 75 Panorama Creek Dr., Rochester 2, N.Y.**

For more details circle #251 on mailing card.

Redesigned Refrigerator Line Has Significant Improvements

Four inches of insulation in cabinets, which maintains a more level temperature for longer periods, is a feature of the completely redesigned Raetone line of refrigerators for institutional use. This feature, together with the greater cooling capacity, reduces running time to effect lower electric consumption and increased condenser life. The complete line includes reach-in refrigerators, freezers, undercounter refrigerators, beverage coolers and water stations. Redesigned in full compliance with the forthcoming National Sanitation Foundation Code, all models have tubular-type six-inch adjustable legs to permit cleaning underneath.

All self-contained units feature a new electric condensator vaporizer that eliminates drippings and the need for floor drains. All models have completely auto-



matic defrosting; large rounded interior corners for easy cleaning; heavy duty shelf and pan slide supports; extra strong inner door liner of "cycolac," a high impact material that is non-conductive and resistant to breakage; self-closing hinges, and magnetic door catches to ensure closing, even when the user has both hands full. **Raetone Commercial Refrigerator Corp., Plymouth Meeting, Pa.**

For more details circle #252 on mailing card.

Clock and Speaker Combination for Centrally Controlled Systems

A new line of electric clock and speaker combinations, companion-mounted in a common panel, is introduced for integration with all types of centrally controlled time, program signal, music or communication systems. Units are furnished with either round or square dial components. **The Standard Electric Time Co., 89 Logan St., Springfield, Mass.**

For more details circle #253 on mailing card.

Speedline Revolving File Expands With Need

Expandable up to six times original capacity in the same floor space, the new Wassell Speedline Work Organizer file is based on the principle of the horizontal

wheel or Roto-Tier. Folders are filed radially, around the hub, which is so balanced that finger pressure of the rim brings the desired file into view. The Roto-Tiers can be installed one at a time and expanded to six deep as the need increases, all in floor space 48 inches wide and 42 inches deep. **Wassell Organization Inc., 225 State St. W., Westport, Conn.**

For more details circle #254 on mailing card.

(Continued on page 242)

NOW EL HAS THREE!

only EL has 3 rinse agents for "hand-polished" results from your dish machine, whatever your water condition

For the first time, there is just the right rinse agent for your water condition and dishroom operation:

JET-DRY®—for above-average conditions

RINSE-DRY®—for normal conditions

New HEAVY-DUTY RINSE-DRY®—for difficult conditions

Hand polishing went the way of hand dishwashing when Economics Laboratory produced the first rinse agents . . . labor-savers that ended toweling forever! Today, with the introduction of Heavy-Duty Rinse Dry, and Jet-Dry, only EL offers 3 different products geared to each individual water condition! Further, an EL injector adds the exact proportion of rinse agent needed by your machine. DRI-VAC and DRY MASTER perform with precision accuracy, no matter how your water pressure varies throughout the day.

Get the EL man to prescribe the right rinse additive for your dishwashing operation. He is your contact with the EL Research Program that maintains EL's unique reputation for "firsts" with dishwashing products that do the job best.

Exclusive EL Precision Injectors

"The first, with the newest, through original research."

MAIL THIS COUPON NOW MH

Economics Laboratory, Inc.
250 Park Ave., New York 17, N. Y.

Gentlemen:
I am interested in brighter glassware, and in improving my dishroom operation. I'd welcome the recommendations of an EL Dishwashing Engineer. I understand you provide this service with no obligation to me.

Name_____

Company_____

Address_____

EL ECONOMICS LABORATORY, INC., 250 Park Ave., New York 17, N. Y.

SEE NEW SCALE MODEL DISH ROOM IN OPERATION At the N.R.A. Show, Chicago, May 22-25th Booths 969-971-973

Pillsbury Instant Potatoes Available in Three Forms

Pillsbury Instant Potatoes in institutional sized packages are available in three forms: potato slices in 2¼-pound boxes that reconstitute to 8½ pounds; potato flakes in five-pound bags, and potato cubes in 2¼-pound cans which yield 10 pounds of diced potatoes. Quick and easy to prepare and store, the potatoes are supplied in new institutional packages, with instructions printed on the back for portion servings at minimum cost. **The Pillsbury Co., Minneapolis 2, Minn.**

For more details circle #255 on mailing card.

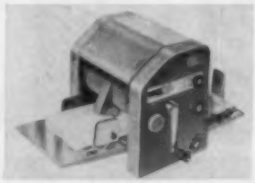
Lime-A-Way Acid Detergent Removes Stains and Soil

An acid detergent for quickly removing stains and food soil which are unaffected or slowly removed by alkaline detergents, Lime-A-Way is safe to use and will not harm skin, nylon, metal surfaces, china or glassware, according to the report. It is developed primarily for use in deliming dish machines, steam tables and other areas on which lime builds up as a result of hot water and steam. It can also be used to clean coffee urns, nursing bottles, drinking fountains and stainless surfaces. **Economics Laboratory, Inc., 250 Park Ave., New York 17.**

For more details circle #256 on mailing card.

Functional Duplicator Has Interleaver/Collator

The new Rex-Rotary D 490 duplicator features special internal concealed lighting for complete control and an interleaver/collator which automatically collates the sheet being imprinted with another sheet previously printed. All controls are easily operated and in full view. The paper breakers and feed tray permit use of all weights of paper, and sizes from three by four to nine by 15 inches. **Rex-Rotary Distributing Corp., 387 Park Ave. South, New York 16.**



For more details circle #257 on mailing card.

Barber-Colman Thermostats Offered in Two Versions

Innovations in the line of Barber-Colman thermostats include improved operation with attractive appearance. Offered in two versions defined by electrical ratings, they are available for light and medium duty service. The thermostats are mounted on a sturdy Bakelite base enclosed by a diecast cover frame with a textured metal face plate. Improvements include a sensitive bi-metal type thermometer and a round, easily read set-point dial with one degree graduations. Finishes include champagne gold or polished chrome covers. **Barber-Colman, 1300 Rock St., Rockford, Ill.**

For more details circle #258 on mailing card.

Transmatic Photocopier Features No-Mix Cartridge

The new Transmatic photocopier features a No-Mix cartridge containing completely pre-mixed solution. The cartridge is easily snapped in and out, thus eliminating waste and the time-consuming task of changing solutions. The Transmatic is budget priced, easy to operate, built for long, trouble-free service, and makes copies in 11 seconds. **Transcopy Inc., 10 Paterson Ave., Newton, N. J.**

For more details circle #259 on mailing card.

(Continued on page 244)

Triangle of Security

EVERY COMMUNITY rests upon a triangle of accomplishment—protecting its families and assuring their future. The three points of this triangle are the Church, the School, and the Hospital.

As a vital partner in community life, local hospitals are continuously investigating new ways in which to improve facilities. In this way, patients are assured of the best health care medical science can provide. The use of wonder drugs, advanced diagnostic equipment, and modern medical and surgical techniques all help toward this end.

And hospitals go even further in their efforts to safeguard community families. Hospital personnel—specialists in the field of health care—are carefully chosen so that their combined skills provide patients with more rapid recovery and shorter hospital stays.

We would like to take the occasion of National Hospital Week—May 7-13, 1961—to add our congratulations to hospitals throughout the country for their contribution to the health and security of the community.

HEALTH • INSURANCE • COUNCIL

Health Insurance Council

Representing the nation's insurance companies

Central Air Conditioning Has Complete Set of Filters

A complete selection of both unit and automatic air filters is available as preselected and matched components in the new line of packaged central station air conditioning units introduced by American Air Filter. The Kennard/Nelson Air Conditioning units are engineered to meet exacting conditions of air quantities, temperatures and humidities and, in the same package, to provide any degree of air cleaning. The new line is available in both horizontal and vertical models in 14 basic sizes with 24 different arrangements per size. **American Air Filter Co., Inc., Dept. PD, 215 Central Ave., Louisville 8, Ky.**

For more details circle #260 on mailing card.

Bed Light and Futura Lamp Feature Cooler Operation

Clamping securely to the inclining headrest or stationary rail of a hospital bed, the Model 14-VCX-711 hospital bed light may be quickly and easily adjusted to any position for patient, nurse, or doctor. The light features a fully-ventilated reflector for cool operation, and is available in brown metallic, ivory or hammerine silver finish. The Faries Futura also features cool operation and flexibility in positioning and is equipped with a fully enclosed, heavily weighted safety-tip base that rights itself automatically, even when tipped to an extreme angle. **Fostoria Corp., 1200 N. Main St., Fostoria, Ohio.**

For more details circle #261 on mailing card.

Pharmaceuticals

Transcoprin

A new pain-relieving compound, Trancoprin combines the time-tested analgesic, aspirin, with a highly effective tranquilizer-muscle relaxant developed by Winthrop and called Trancopal. Extensive clinical testing indicates a high degree of effectiveness and safety in use in a variety of conditions. Control of the "pain complex", which usually includes anxiety and tension, as well as the tendency of aspirin to control fever or inflammatory reactions makes the product especially effective. **Winthrop Laboratories, 1450 Broadway, New York 18.**

For more details circle #262 on mailing card.

Phazyme

An antiflatulent, Phazyme contains in the outer layer, for release in the stomach, pepsin, diastase and activated dimethyl polysiloxane, and in the inner core for release in the duodenum, pancreatin and activated dimethyl polysiloxane. It is indicated for relief of distress, such as bloating and flatulence. It is supplied in tablet form in bottles of 50 and 100. **Reed & Carnrick, 30 Boright Ave., Kenilworth, N.J.**

For more details circle #263 on mailing card.

Lyovac Thrombolysin

Lyovac Thrombolysin, fibrinolysin, is intended to promote the dissolution of certain intravascular thrombi. It is prepared by the activation of a human blood plasma fraction by streptokinase. It is indicated for use in phlebothrombosis, thrombophlebitis, pulmonary embolism and thrombosis of arteries. It is packaged in 100 cc vials, each containing 50,000 MSD units. **Merck Sharp & Dohme, Div. of Merck & Co., Inc., West Point, Pa.**

For more details circle #264 on mailing card.

Lomotil

Supplied in unscored, uncoated white tablets for oral use, Lomotil inhibits excessive gastrointestinal propulsion and is indicated in treatment of acute or chronic diarrhea. Although structurally related to some narcotic drugs, it exerts essentially no analgesia and no evidence of addiction has been reported in clinical use in the recommended dosage. **G. D. Searle & Co., P.O. Box 5110, Chicago 80.**

For more details circle #265 on mailing card.

Syntocinon Nasal Spray

Syntocinon Nasal Spray is an aqueous solution of Syntocinon, one of the polypeptide hormones of the posterior lobe of the pituitary gland. A synthetic product, the pharmacologic and clinical properties of Syntocinon are described as identical with the principle of the natural hormone. It is indicated in the treatment of a number of complications associated with lactation, and is supplied in plastic squeeze bottles. **Sandoz Pharmaceuticals, Hanover, N.J.**

For more details circle #266 on mailing card.

Literature and Services

• **Bulletin No. H-269**, describing all phases of the "60" push-button sterilizer control system through specifications and explanatory drawings, and **Bulletin No. H-270**, describing the Castle Manual Sterilizer Control System, are available from Wilmot Castle Co., 1947 Henrietta Road, Rochester 3, N. Y.

For more details circle #267 on mailing card.

• **Catalog Form No. 11160** illustrates and describes the complete line of casters, glides and other special hospital equipment available from Faultless Caster Corp., Dept. PR-280, Evansville 7, Ind. Special listing is given to "Condux" electrically conductive casters and wheels which dissipate static electric charges by providing an electrical contact between operating tables, stretcher cots and instrument stands.

For more details circle #268 on mailing card.

• A new 40-page brochure released by Lennox Industries Inc., entitled **"Fresh Air Electric Heating by Lennox,"** presents methods of heating by electricity and demonstrates the desirability of ducted systems. A brief presentation of heating products in the Lennox line is followed by a discussion of electric heating applications, including six pages of floor plans.

For more details circle #269 on mailing card.

• **"Introducing the New Telefunken 600 Dictating Machine"** is the title of an informative four-page leaflet prepared by Inter-Continental Trading Corp., Telefunken Div., 90 West St., New York 6. The precision built dictator/transcriber is lightweight, compact and efficient and the folder gives full descriptive information on the machine and its operation.

For more details circle #270 on mailing card.

(Continued on page 247)

TWICE as efficient
MORE economical
LESS maintenance

MARATHON TWIN TISSUE SERVICE

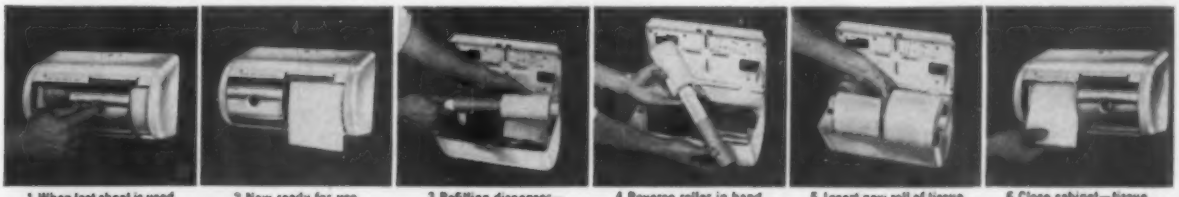
The Marathon Twin-Tissue Dispenser cuts washroom maintenance costs. The unique sliding-door feature means that a new roll is always handy—but not until the first roll is completely used. This reduces waste. No spare tissue is needed in the washroom. The Twin-Tissue Dispenser is theft-proof and simple to clean and maintain.

MARATHON QUALITY TISSUE

- Fully bleached
- Linenized embossed
- Extra soft
- Fast rate of absorbency

- Premium softness
- Pure white
- Sure-cut perforation
- Strong 2-ply tissue
- Instant absorbency
- Completely disposable

REFILLING INSTRUCTIONS



1 When last sheet is used, slide door to left.

2 Now ready for use.

3 Refilling dispenser—open cabinet and remove roller unit.

4 Reverse roller in hand and remove empty core.

5 Insert new roll of tissue on roller and replace in cabinet.

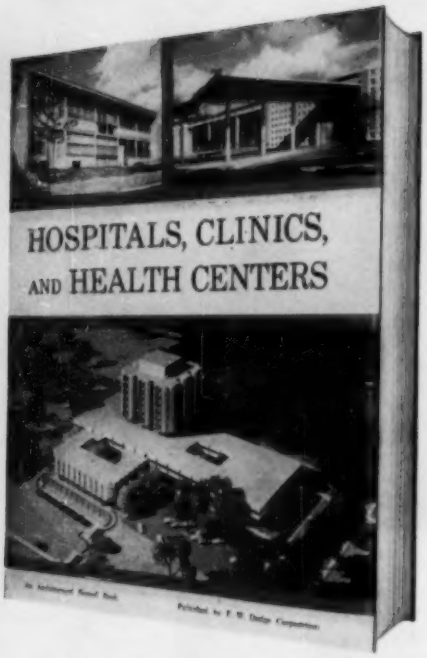
6 Close cabinet—tissue ready for use.

For industrial towels + tissue...

you can't beat marathon

A Division of American Can Company MENASHA, WISCONSIN

For additional information, use postcard facing back cover.



New illustrated survey of medical buildings

HOSPITALS, CLINICS, AND HEALTH CENTERS

by the editors of Architectural Record

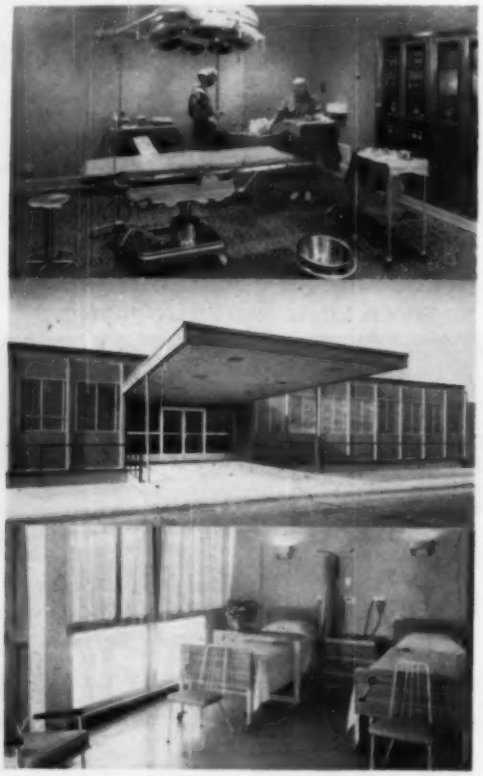
265 pages, large 8¾ x 11⅝" size
700 photographs, plans, and diagrams
Only $9.75

Here, in one book are the newest, most effective ideas for the planning of hospitals and other medical facilities. Divided into four major sections, this valuable sourcebook covers practically the entire range of medical building types: hospitals, special facilities, rehabilitation centers, health centers, clinics, and doctors' offices.

Containing sixty presentations and discussions, HOSPITALS, CLINICS, AND HEALTH CENTERS thoroughly examines the latest advances in medical building design. Each project studies a particular planning problem and its solution, and is graphically illustrated with numerous interior and exterior photographs, floor plans, and diagrams. Carefully choosen for their value, variety, and lasting interest, they provide vital background information needed to solve planning problems effectively.

Also included are authoritative technical articles on planning such specific elements as X-ray suites, pediatric units, and surgical suites. In addition it thoroughly analyses these important subjects: efficient handling of hospital traffic, planning of supply systems, air distribution in operating rooms, hospital electrical facilities, design of teletherapy units, and mechanical and electrical systems for health centers.

Designed specially for those who are responsible for the planning of modern medical facilities, HOSPITALS, CLINICS, AND HEALTH CENTERS will also be of particular interest to doctors and other practitioners planning an office or "professional building." It is the most stimulating, up-to-date source of ideas available today.



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Send me . . . . copies of Hospitals, Clinics, and Health Centers @ $9.75 each. Within ten days I will either remit the price, plus a few cents postage, or return the book(s) without cost or obligation.

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☐ Check enclosed. Same return privilege, Dodge pays postage.

• A 12-page booklet, offering a complete hospital floor control program, is available from the Kent Co., Inc., Rome, N. Y. The booklet describes in detail **"The Microstatic Technic,"** a cleaning procedure for all hospital areas, which employs a detergent germicide solution in conjunction with a vacuum especially designed for hospital use.

For more details circle #271 on mailing card.

• Low-cost forms covering all aspects of patients' medical records, which may also be used to record case histories of long-term hospital patients, are described in **circular NH, "Standardized Records for Nursing Homes,"** offered by Physicians' Record Co., 3000 S. Ridgeland Ave., Berwyn, Ill.

For more details circle #272 on mailing card.

• **Brochure 8035** is a six-page booklet offered by the DuKane Corp., St. Charles, Ill., describing and illustrating audio-visual automatic nurses' call equipment for nurse-patient and staff communications; automatic, patient, bedside monitoring, and multi-channel music/program distribution systems.

For more details circle #273 on mailing card.

• Produced by White Laboratories for medical and lay groups showings, a black-and-white 16mm. **film entitled "69.3"** is a capsule history of medicine from ancient times to the present. How medical progress has helped to raise average life expectancy is the theme of the 13½-minute film, available from Institute of Visual Communications, Inc., 40 E. 49th St., New York 17.

For more details circle #274 on mailing card.

• **"Guide to Uniforms of Synthetic Fabrics"** is the title of a new booklet offered by Angelica Uniform Co., 1427 Olive St., St. Louis 3, Mo., as an aid in the selection of synthetic fabric uniforms for hospital employes. For those hospitals operating their own laundries, the booklet gives instructions for adapting present equipment to handle synthetics.

For more details circle #275 on mailing card.

• A 470-page catalog illustrating over 4200 surgical instruments is now available from the **Miltex Surgical Instrument** Div., E. Miltenberg, Inc., 43 Great Jones St., New York 12. Included are instruments developed for special fields, stainless steel surgical needles, Erka blood pressure apparatus and Heine diagnostic instruments.

For more details circle #276 on mailing card.

• The qualities of **Resolite Security Panel,** a combination of steel mesh and polyester resin translucent panels providing a functional and decorative building material for opaque windows, stair guards, canopies and other architectural uses, are described in a four-page leaflet available from Resolite Corp., Zelienople, Pa.

For more details circle #277 on mailing card.

• **"Power Without Interruption With UPS"** is the title of a brochure issued by Consolidated Diesel Electric Corp., 880 Canal St., Stamford, Conn. It describes available Uninterrupted Power Supplies, which provide absolutely continuous power in the event normal power sources fail.

For more details circle #278 on mailing card.

• **"Gevaert X-Ray Bulletin"** is the name of a new international review, printed in English, Dutch, French, German, Spanish and Italian, and intended primarily for radiologists. Each issue will contain short descriptions of a different national Society of Radiology, articles dealing with problems in the field, and a survey of the latest books on the subject. The publication is available to radiologists without cost from the Low X-Ray Corp., 161 Sixth Ave., New York 13.

For more details circle #279 on mailing card.

• The line of sterile, disposable plastic petri dishes and other labware, as well as a number of completely new products, especially in the tissue culture field, are described in the new **Falcon Catalog "G"** which also lists prices. Available from Falcon Plastics, a division of B-D Laboratories, 5510 W. 83rd St., Los Angeles 45, Calif., the catalog includes a new system which simplifies ordering and expedites shipping.

For more details circle #280 on mailing card.

• The varied uses of **"Borcherdt's Malt Soup Extract"** in the control of constipation in infants and geriatrics as well as other patients are presented in a new booklet available from Borcherdt Co., 217 N. Wolcott Ave., Chicago 12. How the product, which contains no drugs and is an AMA Council-accepted dietary food, performs as a laxative food supplement and for dietary treatment of pruritus ani is discussed, and action and composition are detailed.

For more details circle #281 on mailing card.

• **The Mark II and Mark III series examining tables** developed by Shampaine Industries, 1920 S. Jefferson Ave., St. Louis 4, Mo., are the subject of a new eight-page brochure which provides information concerning the exclusive features of the modern tables, the various positions attainable, operation and construction.

For more details circle #282 on mailing card.

• **"Target—Inflammation. . . . Agent—Chymotrypsin"** is the title of a color motion picture showing and discussing inflammatory reactions in a wide variety of conditions frequently encountered, and the three general uses of Chymotrypsin. Prints may be obtained from Armour Pharmacuetical Co., Box 511, Kankakee, Ill.

For more details circle #283 on mailing card.

• **"A Case for understanding"** is the title of a new film designed for orientation of medical students, interns and residents as a "major step toward solution of the problems of hospital-physician relations." Produced by the American Hospital Assn., under a grant from Abbott Laboratories, North Chicago, Ill., the film is available on loan from either organization or from the American Medical Assn. which cooperated in its production.

For more details circle #284 on mailing card.

• Automatic control of flying insects by **Gardner Electronic "Insect-O-Cutors"** is the topic of a new pamphlet offered by Gardner International Corp., Box 2717 — Hamilton Station, Pompano Beach, Fla.

For more details circle #285 on mailing card.

• **A general survey of the causes and effects of hypoxia** is presented in a new medical film prepared by the Oxygen Therapy Dept., Linde Co., Dept. HF, 270 Park Ave., New York 17. The 30-minute, 16mm sound, color motion picture reviews the basic physiology of respiration, demonstrates clinical recognition of the major types of hypoxia, and should be of interest to inhalation therapists, supervisory nurses and other hospital staff personnel.

For more details circle #286 on mailing card.

• A 36-page booklet, **"X-Ray Protective Materials,"** containing details and specifications to serve basic needs for preparation of the best possible installation of x-ray shielding and other radiological protection, is offered by the Ameray Corp., X-Ray Protective Div., Kenvil, N. J.

For more details circle #287 on mailing card.

• A 16mm, 25-minute, color, sound film entitled **"Frontiers of Allergy"** affords a visual presentation of the overall subject from its basic mechanisms to methods of treatment. The film is obtainable through the Audio-Visual Dept., Schering Corp., 1011 Morris Ave., Union, N.J.

For more details circle #288 on mailing card.

• The **"Buyers' Specification — Latex Foam"** is available in revised form from the Latex Foam Div., Rubber Manufacturers Assn., 444 Madison Ave., New York 22. Included is a range of compression standards for latex foam mattresses with sharp definitions for accurately labeling the core.

For more details circle #289 on mailing card.

• A brochure, **"Handprints on Vicrtex,"** illustrates a new method for blending individual design imagination with Vicrtex wallcovering patterns to create new effects for exclusive decoration. The booklet, available from L. E. Carpenter & Co., Inc., Empire State Bldg., New York 1, also gives information on samples and original art work.

For more details circle #290 on mailing card.

• Eight authoritative articles on the subject of sterilization procedures and controls are included in a 132-page booklet published by Becton, Dickinson & Co., Rutherford, N.J. A compilation of the **Becton, Dickinson Lectures on Sterilization** presented as part of the curriculum in bacteriology at Seton Hall University College of Medicine and Dentistry, the topics include sterilizing surgical equipment, the control of cross infection, skin antisepsis, and the control of sterilization procedures.

For more details circle #291 on mailing card.

Book Announcements

Beckman, "Pharmacology, The Nature, Action and Use of Drugs," 2nd ed., 805 pp., $15.50. Bollo, "Introduction of Medicine and Medical Terminology," 356 pp., $5. **W. B. Saunders Co., W. Washington Sq., Philadelphia 5, Pa.**

For more details circle #292 on mailing card.

Suppliers' News

Becton, Dickinson & Co., Rutherford, N.J., announces a new **Cardiovascular and Special Instrument Division,** to provide rapid, individualized service to physicians and hospitals specializing in cardiovascular and thoracic diseases. The new CSI division will manufacture instruments and instrument prototypes to the specifications of individual physicians, and it will expedite rapid shipment of all specially designed equipment, make its research and development facilities available for consultation, and keep abreast of current trends.

Shampaine Industries, Inc., announces removal of the **O.E.M. Corporation** division from **East Norwalk, Conn.** to the **Shampaine plant in Roselle, N.J.,** as of March 15, 1961. The new location offers every facility for production of the expanding O.E.M. lines of therapy products.

Smith, Kline & French Laboratories, 1530 Spring Garden St., Philadelphia 1, Pa., manufacturer of pharmaceuticals, announces a revision of its distribution policy. Under the new arrangement, bulk or hospital packages will be stocked by wholesalers for sale to all hospitals. Wholesalers are also authorized to accept from hospitals returns of unopened bulk packages, according to the announcement.

Universal Motor Co., Oshkosh, Wis., manufacturer of electric power and light plants, announces it has joined the **J. M. Nash Co.** organization, also of **Oshkosh.** The acquisition of the **Universal Motor Co.** by **Nash** was completed in an exchange of stock transaction. The announcement states that no changes in Universal personnel are involved, and that the company is planning an aggressive development and expansion program.

Vapor DRUM MODULĀTIC water tube boiler

World's Most Compact Heat and Power Package

200 BHP in only 40 sq. ft.

This pocket-sized power package hits the right note with engineers everywhere. It's compact, efficient...takes only 5′ x 8′ of floor space. Costs less to install...delivered completely assembled, wired, pre-tested; needs no special foundation, fits through plant doors, can be installed in any unused corner or aisle. Costs less to operate...modulating controls produce steam only "on demand," save fuel. Full steam pressure in 5 minutes from cold start.

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Ends early-morning shift to fire-up. Fully automatic, push-button operation. Most flexible...multiple-unit installations meet widely-varying, or peak-load steam requirements. Single, coordinating control cuts individual units on or off as steam demand varies. Easiest to maintain...all parts are readily accessible. Burns oil, gas, or both fuels. Meets all codes.

Complete Line of Boilers. 20 to 200 hp; 0-15, 5-150 psi steam pressure; 670,000 to 6,690,000 btu/hr.

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Our requirements are:

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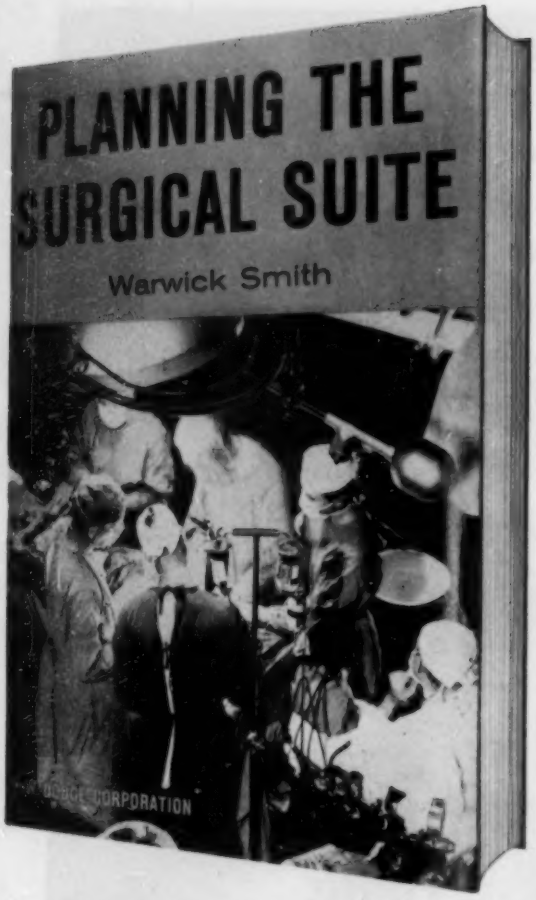
The first authoritative guide for planning the heart of the hospital



PLANNING THE SURGICAL SUITE

by Warwick Smith

456 pages, 6 x 9" size with over 75 illustrations and 17 guide tables and charts only $12.75

The heart of the hospital is its surgical suite. Because of its critical functions, the operating room and its environs must be designed to work efficiently under all conditions. This is a fact recognized by all administrators and designers of hospitals. Equally recognized is the difficulty involved in developing a truly efficient and flexible plan for a surgical suite.

Much time and money has been wasted in building and remodeling surgical suites. The inherent flaws are soon revealed in a suite design which did not consider all of its required functions. Consequently, within weeks of its occupation, it is often found necessary to remodel or improvise upon the original design.

PLANNING THE SURGICAL SUITE is aimed directly at this problem. This unique guide explains how the intended functions of a surgical suite affect its organization and design, and describes the methods of translating these into actual facilities. With the aid of tables, charts, and checklists, it provides for a complete analysis of the function and design of the operating room complex.

Hospital administrators, surgical supervisors, staff surgeons and anesthetists—anyone whose responsibility embraces the whole hospital operation, or is limited to the surgical area—will find PLANNING THE SURGICAL SUITE of vital interest.

Considers all aspects, including:

- **role of the surgical suite**
- **size, plan, and location**
- **traffic flow for both patients and staff**
- **storage for clean and sterile supplies**
- **sterilization facilities**
- **detailed arrangement of rooms**
- **materials and finishes**
- **heating, ventilation, and air-conditioning**
- **engineering services**

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Send me . . . . copies of Planning the Surgical Suite @ $12.75 each. Within ten days after receipt, I will either remit payment, plus postage, or return the book(s) without obligation.

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About the author . . . .

Warwick Smith has made an intensive, twelve-year study of hospital design, with special emphasis on the surgical suite. Although a native Australian, Smith has designed hospitals and medical facilities while working for architectural firms in England, Sweden, and the United States. An associate of the Royal Institute of British Architects and the Royal Australian Institute of Architects, the author was awarded the Henry Saxon Snell Prize in 1954 for research in hospital architecture.

INDEX TO ADVERTISEMENTS

USE THIS PAGE TO REQUEST PRODUCT INFORMATION

The index on this and the following page lists advertisements in this magazine alphabetically by manufacturer. For additional information about any product or service advertised, circle the manufacturer's key number on the detachable postcard and mail it. No postage is required.

Products described in the "What's New" pages of this magazine also have key numbers which appear in each instance following the description of the item. For more information about these items, circle the appropriate numbers on the postcard and mail it, without postage, to The Modern Hospital.

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1050 MERCHANDISE MART

CHICAGO 54, ILLINOIS

NEW PILLOW SPEAKER WITH REMOTE CONTROLS PUTS SERVICE...SECURITY...ENTERTAINMENT AT PATIENT'S FINGERTIPS

Executone's advanced engineering—and thorough knowledge of hospital problems—has produced this remarkable multi-purpose pillow speaker. The new unit is an audio-visual nurse-call cord set . . . a high-quality sound reproducer . . . radio station and TV channel selector . . . and volume control—all in one. Check these unique features:

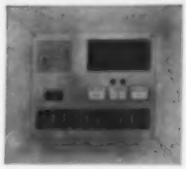
- Eliminates the expense and clutter of individual radios. Brings entertainment from one central source. Patient may choose any one of five channels of AM or FM broadcasts, recorded music, chapel services, etc.
- Separate TV control provides simplest possible channel selection.
- Reception is clear, uniform, static-free. Patients in adjoining beds are free to choose radio or TV programs independently, without interference. Patients who prefer to sleep or read are not bothered.
- Nurse call button—and selector buttons—have durable palladium contacts of special design, for utmost reliability.
- Sturdy housing has high resistance to shock and moisture; can be quickly sterilized.
- All patient-nurse conversations utilize the separate wall station, to assure clear uninterrupted voice communication at all times. This ultra-sensitive unit can monitor even the faintest sounds in a patient's room . . . can't be fouled or disengaged.
- Foolproof volume control affects only entertainment; does not alter patient-nurse communication level.
- Bed clamp cannot be removed or lost . . . will not stain or damage linens.
- Entire cord-set is instantly removable . . . can be freely interchanged with other specialized Executone cord-sets (geriatric, explosion-proof, etc.) If the plug is accidentally pulled out, nursing personnel is automatically summoned.
- Wall station lights assure patient of proper call registration and maintenance of his privacy.

FROM EXECUTONE: A REVOLUTION IN BED-CARE COMMUNICATIONS!

ADVANCED EXECUTONE SYSTEMS FOR NEW AND EXISTING HOSPITALS

Audio-Visual Nurse Call Systems

Administrative Communications



Doctor's Register and Message Center Systems

Sound Distribution and Paging Systems

For detailed information, write to:

Executone, Inc., 415 Lexington Avenue, Dept. 8-7, New York 17, N. Y.

Name_____

Hospital_____

Address_____ City_____ State_____

In Canada: 331 Bartlett Ave., Toronto

Executone

COMMUNICATION and SOUND SYSTEMS

a key member of your Oxygen Therapy team wears this cap

He drives a **Linde** delivery truck. And to you, this is important—it means he's backed by a leading manufacturer of Oxygen U.S.P....by the fastest, most flexible distribution network in the country.

Naturally, you can rely on him to fill every routine need. But what's more important—Linde's "Emergency Oxygen Back-up" gives you added assurance that your out-of-the-ordinary demands can be met. When the need is urgent, Oxygen U.S.P. is on its way to you in minutes.

Dependable oxygen delivery is vital to a hospital. This is just one of the many services Linde is ready to offer you. To learn about the others, call your nearest Linde representative or distributor or write Linde Company, Division of Union Carbide Corporation, 270 Park Avenue, New York 17, N. Y. In Canada: Union Carbide Canada Limited, Linde Gases Division, Toronto 12.

Linde / first in Oxygen U.S.P.

LINDE COMPANY UNION CARBIDE